Informal Payments in the Public Health Sector in Albania: A Qualitative Study

Final Report

July 2004

Prepared by:

Taryn Vian, MSc
Consultant
Abt Associates Inc.

Kristina Gryboski, PhD
Program for Appropriate Technology in Health

Zamira Sinoimeri, MD, MSc
Consultant
Partners for Health Reform*plus*/Albania

Rachel Hall Clifford, MA
Consultant
Abt Associates Inc.

Partners for Health Reform*plus*

Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:
Development Associates, Inc. ■ Emory University Rollins School of Public Health ■ Philoxenia International Travel, Inc. ■ Program for Appropriate Technology in Health ■ Social Sectors Development Strategies, Inc. ■ Training Resource Group ■ Tulane University School of Public Health and Tropical Medicine ■ University Research Co., LLC.

Funded by:
U.S. Agency for International Development

Order No. TE 047

Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- *Implementation of appropriate health system reform.*
- *Generation of new financing for health care, as well as more effective use of existing funds.*
- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

This document was produced by PHR*plus* with funding from the US Agency for International Development (USAID) under Project No. 936-5974.13, Contract No. HRN-C-00-95-00024 and is in the public domain. The ideas and opinions on this document are the authors and do not necessarily reflect those of USAID or its employees. Interested parties may use the report in part or whole, providing they maintain the integrity of the report and do not misrepresent its findings or present the work as their own. This and other HFS, PHR, and PHR*plus* documents can be viewed and downloaded on the project website, www.PHRplus.org.

July 2004

Recommended Citation

Vian, Taryn, Kristina Gryboski, Zamira Sinoimeri, and Rachel Hall Clifford. July 2004. *Informal Payments in the Public Health Sector in Albania: A Qualitative Study.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

For additional copies of this report, contact the PHR*plus* Resource Center at PHR-InfoCenter@abtassoc.com or visit our website at www.PHRplus.org.

Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: USAID/Albania

and: Karen Cavanaugh, CTO
Health Systems Division
Office of Health, Infectious Disease and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

This report presents the results of a qualitative survey conducted by the Partners for Health Reform*plus* Project to examine the practice of informal payments for health in Albania's public health system. The main objectives of the study were to better understand the perspectives and experiences of the public and providers about why informal payments occur, the process through which such payments are made, and what these payments mean in the context of Albanian society and the public health care delivery system. In-depth interviews and focus group discussions were held with members of the public, health care providers, and health facility administrators in three districts.

The evidence from this study suggests that the practice of informal payments for health services is more common in large towns and cities, and in inpatient care settings, particularly for surgery, childbirth, and gynecological care. Factors influencing informal payments in Albania include low salaries of health staff; a belief that health is extremely important and worth any price; a desire to get better quality care; fear of being denied treatment or missing the opportunity to get the best outcome possible; and the tradition of giving a gift to express gratitude. The findings provide insight into the meaning of gifts versus informal payments, highlighting important discrepancies between the providers' and the public's perceptions. Many providers feel that patients voluntarily give informal payments; however, most public informants do not feel that informal payments are voluntary but rather necessary to obtain services. The study shows that the interaction between patients, relatives, and various personnel at the many service delivery points in Albania is complex. Finally, informants' perspectives on the potential effects of informal payments vary. The paper includes a discussion of these findings and their implications for efforts to improve health care and service delivery in Albania, with some recommendations on how to address related issues.

Table of Contents

List of Tables

Acronyms

FGD	Focus Group Discussion
IDI	In-Depth Interview
LSMS	Living Standards Measurement Survey
PHR*plus*	Partners for Health Reform*plus*
USAID	United States Agency for International Development

Acknowledgments

The authors of this report include Principal Investigator Taryn Vian (Assistant Professor of International Health at the Boston University School of Public Health), Kristina Gryboski (Program Officer for Program for Applied Technology in Health), Zamira Sinoimeri (Technical Specialist, Partners for Health Reform*plus*/Albania), and Rachel Hall Clifford (Ph.D. candidate in the Boston University Department of Anthropology). Kristina Gryboski helped design the survey instruments and training materials, and led the data analysis. Zamira Sinoimeri coordinated the fieldwork for the study. Rachel Hall Clifford coded and analyzed much of the data collected.

A study of this size and complexity requires the close collaboration of many people. We would like to acknowledge the participation of the following people who were involved in study design, implementation, and analysis.

U.S.-based participants in the research included Sara Bennett and Kate Stillman (PHR*plus* Project/Bethesda) who provided technical direction, feedback, and support at all stages of the study. Kim Smith (PHR*plus* Project/Bethesda) provided early support and conducted the first training of the Albanian research assistants in Tirana. Matt Fox (Boston University School of Public Health) helped design the sample selection process.

The Albania-based research team led by Dr. Sinoimeri included Merita Xhumari (Professor of Social Work), who supervised the research assistants. Elona Nasufaga (Administrative Assistant, PHR*plus*/Albania) provided field support and reviewed transcripts in both Albanian and English. Hamlet Bezheni, Adelina Albrahimi, and Albana Qazimi (Lecturers at the Foreign Languages University in Albania) and Fatmir Vrapi (Lecturer at the Polytechnic University of Tirana) translated Albanian transcripts into English. Altin Malaj (PHR*plus*/Albania) helped with selection of sample areas.

We would also like to thank the technical guidance and support of the PHR*plus*/Albania Chief of Party Dr. Jan Valdelin, and the PHR*plus* E&E Regional Coordinator Mark McEuen. We are appreciative of USAID/Albania's support, especially that of Pamela Wyville-Staples.

Finally, we are grateful for the hard work of our Albanian research assistants who led focus group discussions, conducted in-depth interviews, took careful notes, and transcribed the information collected by audiotape.

Isuf Shehu	Admir Meko	Almandina Guma
Ada Kuke	Valdete Hoxha	Arta Hoxha
Ina Lalzi	Selim Kacidhe	Altina Peshkatari
Stela Prifti	Edlira Dajko	Albana Bufi (guide, Fier)

Qualitative data collection is very dependent on the skills of the people collecting the data, and the high quality of our data is due in large part to their professionalism and dedication.

Executive Summary

The Partners for Health Reform*plus* Project conducted qualitative research on the practice of making unofficial, "informal" payments to medical personnel within government health facilities in Albania. Informal payments are defined as cash or other things given to government staff for services where payment is not required by the government. Under-the-table payments pose a danger to achieving progress on health reform and indicate problems in the accountability structure of public services. The aim of the research was to understand the perspectives and experiences of the public and providers about why the payments occur, how they occur, and what they mean in the context of Albanian society and the public health care delivery system.

The fieldwork took place from November to December 2003. Albanian researchers gathered information from 131 informants in three districts: Berat, Kuçova, and Fier. The team conducted focus group discussions and in-depth interviews with doctors, nurses, and administrators working in the public sector, as well as members of the general public. The researchers explained to respondents that the study was only interested in informal payments, and was not asking about official, government-approved payments. This report presents the findings of the study.

Types and Variation in Informal Payments

The evidence from this study suggests that the practice of informal payments for health services is more frequent in large towns and cities, and higher amounts seem to be requested from villagers who go to cities to seek specialized care. Informal payments are less common in areas where there is greater social cohesion, including rural areas and smaller urban communities.

The community ties between providers and residents in rural areas and smaller urban communities seem to deter informal payments, both because providers would be embarrassed or feel loss of professional reputation if people were to know they were accepting informal payments, and because it is common to exempt from payment people who are well known to the provider. In addition, there is less medical technology available in smaller urban or more rural communities; thus, there is less benefit (in terms of access to quality services) to be derived from making an informal payment.

Albania informants described informal payments more often in the setting of inpatient care, particularly surgery, childbirth, and gynecological care. Informal payments in Albania appear to be higher for providers with more qualifications and better reputations.

For the general public in Albania, there seemed to be some problems distinguishing official from unofficial payments. Both insured and uninsured people give informal payments. The researchers observed that policies regarding co-payments or exemptions for insured patients were not really understood and may not be uniformly applied.

Gifts and Informal Payments

The Albania study provided insight into the meaning of gifts versus informal payments. Gifts are seen as voluntary, token expressions of sentiment, and this is perceived as less troubling than when informal payments are expected or demanded by providers as part of a health care transaction. Gifts are made to reward a caregiver for being the bearer of good news or because the patient is grateful for having received a good health outcome. However, providers and general public respondents did not always seem to have the same perceptions about when an informal payment was truly a gift, or when it was a bribe or unofficial fee. For example, providers thought they might offend patients by not accepting informal payments given "voluntarily" by patients; yet, in the eyes of public informants these were not voluntary, but obligatory payments to obtain services. The "have a coffee" informal payments in Albania were often perceived as an informal payment but also motivated at least to some extent by a traditional desire to express appreciation. In Kuçova and to some extent Fier, it was difficult to distinguish small cash gifts from other types of informal payments.

Reasons for Informal Payments

Factors influencing informal payments in Albania included low salaries of health staff; a belief that health is extremely important and worth any price; a desire to get better quality care; fear of being denied treatment or missing the opportunity to get the best outcome possible; and the tradition of giving a gift to express gratitude. Some other reasons given for the rising prevalence of informal payments were the lack of deterrents, social norms influencing providers, and the growth of capitalistic values in Albanian society. Many providers feel that patients voluntarily give informal payments; however, most public informants did not feel that informal payments were voluntary.

The most salient belief of both provider and general public informants was that the practice of informal payments was caused by low government salaries paid to providers. Whether or not these beliefs are based in fact, it will be important to incorporate the beliefs into any behavioral change strategies that are proposed to complement systems strengthening activities in the health sector.

The public and provider informants in Albania often described more that one reason for any particular example of informal payment exchange. The reasons and context of giving and receiving informal payments is a complex social encounter. Both providers and patients go through a process of interpreting the expectations of the giver and receiver at the time it occurs.

Process of Making Informal Payments

This study provides a detailed understanding of the process of informal payments, including who receives them, how people determine what they are expected to pay, whether payments are in cash or in kind, price discounting, and other details. Informal payments are paid before, during, or after the service. Payments are made to nurses, doctors, cleaners, guards, and in some cases to non-staff "brokers."

The findings show that the interaction between patients, relatives, and various personnel at the many service delivery points is complex. As patients navigate the system, they seek information from other patients, friends, and relatives to try to establish who and what they need to pay to get proper attention, or any attention from personnel. Patients must read indirect clues from providers, in addition to (in some cases) dealing with brokers outside the health system or nurses to determine amounts to pay. Patients experience much ambiguity and uncertainty. When directly told they need to

pay, they also don't feel certain about which are official fees versus informal payments. Many doctors feel uncomfortable interacting with patients because they don't want to appear to be soliciting informal payments.

The study found some evidence of informal payment discounting based on ability to pay in Kuçova, but not in other areas. More often, respondents reported that informal payments were negotiated upwards as patients realized (by observing the facial expression or manner of the doctor) that their initial offer was too low. This finding is important because it shows that the informal system is not automatically providing safeguards for the very poor and vulnerable populations.

Effects of Informal Payments

Public informants see informal payments as unfair and abusive, hurting poor and vulnerable groups who cannot afford to pay, creating uncertainties and anxiety during the care-seeking process, and corroding the patient-provider relationship. Providers perceive that informal payments harm their professional reputation, induce unnecessary medical interventions, create discontinuity of care or poorer quality care, and increase the risk of harm to providers. Most providers indicated that they would prefer not to be in the situation of accepting informal payments.

At the same time, health is seen as "priceless" in Albanian culture, and people are willing to pay to gain access to care and for the prospect of better service. The public feels uncertain about how informal payments influence their care, but they pay in the hope it might lead to better health outcomes. Some people stated that they would find the money however they could, even if it meant going into debt, to make the necessary informal payments.

Implications for Health Reform and System Strengthening Activities

Based on the perceptions of the informants in this study, many Albanians are concerned about informal payments and view them negatively, even while they see them as necessary or unavoidable in the short run. The study detected a lot of variation in attitudes and perceptions, and the research team cannot propose a universal model for explaining them. Rather, there are many contextual factors and individual, household, and community beliefs and behaviors that must be considered. The authors highlight the following implications of the study findings for policy reform and health system strengthening.

1. Variation in attitudes and perceptions makes it difficult to create a common policy reform agenda on this topic. Focusing on the most harmful effects, and targeting the most vulnerable populations, may be one way to gain consensus.

2. Insufficient provider remuneration is the factor most frequently cited as motivating informal payments, and should be addressed.

3. Informal payments are now one of the only ways Albanian patients have to make sure health providers are being held accountable. Alternative accountability structures may help reduce informal payments.

4. Both insured and uninsured patients are making informal payments. The practice of informal payments may be reducing public willingness to participate in the social insurance system.

5. Health reforms or system strengthening activities cannot easily separate or ignore gift giving,

although the effects of gift giving on provider behavior and accountability are not yet well understood.

6. People generally look to the state to end informal payments, but some also see value in community participation to enhance accountability. Getting ordinary citizens involved in oversight or transparency initiatives may be a useful complement to regulatory and bureaucratic reforms.

Conclusions

In the eyes of Albanian providers and the public, informal payments are both a necessary coping mechanism and a destructive practice that hurts efficiency, trust, and health. Informal payments are motivated by many factors, and great variation exists in perceptions of gifts versus other informal payments, the process of making informal payments, and people's attitudes toward the payments. Public discussion is needed to air these differences and to explore common interests. A coalition of stakeholders can help keep this issue at the front of the policy agenda, leading the way back to accountable public services that promote the nation's health. Accountability will be enhanced as government officials and civil society work together to identify possible solutions and decide what roles government and the people should play in implementing change.

1. Introduction

The Albanian government is initiating reforms to improve financing and delivery of health care. In order for the health reforms in Albania to succeed, policymakers need a better understanding of the current practice of informal, under-the-table payments to medical personnel in government health facilities. Informal payments are defined as cash or other things given to government staff for services where payment is not required by the government (Lewis 2000).

The Partners for Health Reform*plus* Project (PHR*plus*) in Albania is providing technical assistance the government to improve the primary health care system. PHR*plus* conducted baseline facility and household surveys in 2003, in the project's two intervention areas (Berat and Kuçova). Based on the analysis of this data, the researchers noted that out-of-pocket expenditures for health care were substantial and the burden of informal payments seemed to be greater for the poor (Partners for Health Reform*plus* Project 2003). To better understand the process of informal payments, PHR*plus* decided to conduct a qualitative study on informal payments to complement the baseline quantitative data already collected. This study was designed to explore motivations behind informal payments in Albania, people's attitudes towards them, how informal payments are given, and perceived advantages, disadvantages, and other consequences of the practice. The research design incorporates elements of Brinkerhoff's conceptual framework for improving accountability in the health sector (Brinkerhoff 2003), which considers stakeholder roles and interests of prime importance.

The study took place between September 2003 and February 2004. Albanian researchers gathered information from 131 informants in three districts: Berat and Kuçova, the two PHR*plus* pilot intervention areas, plus Fier, a control area also included in the baseline quantitative survey. The team conducted focus group discussions and in-depth interviews with doctors, nurses, and administrators working in government health facilities, in addition to members of the general public. This report presents the findings of the study and implications for the design of health reforms and more accountable government health services.

2. Background and Study Rationale

Albania started on the transition to a market economy and democratic governance system in 1991. Since that time, there have been many political changes and some social crises, as described in detail elsewhere (European Observatory on Health Care Systems 1999). The health system is challenged by health problems reflecting chronic disease patterns as well as infectious diseases (Albania Ministry of Health 2002). A network of government health facilities, from hospitals to health posts (*ambulanza*), provides services to most of the population, although private medical practice is growing, especially in urban areas (Valdelin 2002). About 40 percent of the population is enrolled in the national health insurance system, which currently covers general physician outpatient care, and full or partial reimbursement for a restricted list of essential medicines (Bonilla-Chacin 2003).

Informal payments to health workers in Albanian government health facilities appear to be high, despite the country's stated policy of providing most health care services free of charge. Studies conducted between 2000 and 2002 suggest that 60-87 percent of Albanian citizens made informal payments to hospital doctors in order to receive services (Albania Ministry of Health 2000; Bonilla-Chacin 2003). The Albanian Living Standards Measurement Survey (LSMS) of 2002 has estimated that out-of-pocket expenditures account for more than 70 percent of total health expenditures, a higher percentage than most other Balkan countries (Bonilla-Chacin 2003). Although it was not always possible for the LSMS to distinguish between official out-of-pocket expenditures and unofficial or informal payments, the study did determine that poorer Albanians spend proportionately more of their income on health services, and are more likely to incur catastrophic health expenditures (Bonilla-Chacin 2003). Thus, the practice of informal payments is likely to hurt the poor more than other segments of the population.

Qualitative data show that, although some cash payments to health workers are freely given as gifts to express gratitude, many Albanians feel forced to make the payments in order to access care (Albania Ministry of Health 2000; Bonilla-Chacin 2003). Anecdotal evidence suggests that informal payments may also have resulted in unnecessary interventions recommended mainly to increase staff compensation (Vian 2003).

Studies in other countries have distinguished different types of informal payments. For example, Ensor (2004) developed a typology to categorize the reasons unofficial payments occur in transitional, resource-constrained economies. He defines three types of informal payments: cost contribution given by patients toward care (i.e., the public "subsidizes" the system); informal payments as a way of obtaining additional services; and informal payments that are a misuse of power and market position by providers. Although attitudes and perceptions vary, many studies make a distinction between gifts of cash or goods to show appreciation, and unofficial payments for other purposes.

International research has also shown that informal payments can have negative impact on access and health status. Informal payments can cause people to forgo or delay seeking care, sell assets to seek care, or lose faith in the health care system (Lewis 2000; Thompson and Witter 2000; Akashi, Yamada, et al. 2004; Falkingham 2004). In addition, some studies have shown that clinical

care is affected by informal payments, with family members giving injections to avoid paying nurses, and doctors recommending procedures in order to increase their income rather than for therapeutic benefit (DiTella and Savedoff 2001; Falkingham 2004). Informal payments in government-run facilities can also create distortions and inefficiencies in health care financing systems, draining revenue needed to support public sector health goals and activities (Ensor 2004). Some studies have found that informal payments make doctors feel humiliated and erode their clinical autonomy by giving more power to patients and patients' families (Balabanova and McKee 2002).

At the same time, researchers have documented some positive attitudes toward informal payments. For example, in some countries informal payments are seen to create continuous relationships between patients and providers, improve staff morale, keep health workers from leaving the public system altogether, and allow patients to show respect to providers who please them (Chawla, Berman, et al. 1998; Balabanova and McKee 2002). Drawing from recent literature, Annex A contains additional observations about informal payments in transitional economies.

Albania is beginning reforms to increase resources for health services, improve efficiency, expand access, and increase quality of care (Nuri 2002). More information is needed about the practice of informal payments to help refine the direction and content of health system strengthening activities. Increased understanding of informal payments can help shape programs designed to change people's attitudes and behavior.

3. Study Design

In this exploratory study, the researchers used focus group discussions and in-depth, semi-structured interviews to document beliefs, attitudes, and perceptions that underlie the practice of informal payments in the Albanian public health sector. The study gathered views about informal payments from many participants in the government system: community members, clinical care providers, and public health administrators. Researchers sought to develop a better understanding of concepts and behaviors, not to test hypotheses or establish facts with statistical significance. The specific objective of the study was to enhance understanding of informal payments in Albania, including how they operate, how they are perceived by the population and providers, and their likely effects.

3.1 Study Areas

The study was designed to include the two pilot districts participating in the PHR*plus* Project demonstration to improve primary health care delivery: Berat (population: 127,837) and Kuçova (population: 35,338).[1] A control district, Fier (population: 199,082) was also included. Fier is considered to have a more heterogeneous population when compared with both Berat and Kuçova. Berat district is somewhat smaller than Fier. Of the three districts, Kuçova is considered the smallest and most isolated. All three districts have urban areas, though Kuçova is the least urbanized. All three districts participated in the baseline quantitative evaluation survey conducted by PHR*plus* in 2003. This intentional parallel design will allow this study to draw on both quantitative and qualitative data for similar populations as reforms are considered.

3.2 Respondents

Within each district, the researchers organized four focus groups with the general public. The team held separate focus groups for men (one urban, one rural) and for women (one urban, one rural). Each focus group had about six participants.[2] Researchers also conducted several individual interviews with community members in each district. Annex B explains the process for selection of public informants and gives the breakdown of the total number of general public respondents (80) by district, urban or rural location, gender, and type of interview (focus group discussion or in-depth interview).

The study also included three categories of health personnel: doctors, nurses, and administrators. Annex B explains the process for selecting provider respondents and gives a breakdown of the total number of provider respondents (51) by district, type of provider, urban or rural location, and type of interview (focus group discussion versus in-depth interview).

[1] 2001 census data, INSTAT (Tirana, Albania)

[2] In Fier, the research team had trouble recruiting six urban women to participate in a focus group, so they held two smaller focus group discussions, one with three participants and one with five participants.

3.3 Implementation

Eleven research assistants, three male and eight female, were selected by PHR*plus* staff in Albania to participate in the study. Most were university students or graduates, conversant in both Albanian and English. Research assistants were given practical training in qualitative data collection methods, as well as orientation to the study objectives and instruments. They were also trained on Informed Consent procedures.

Research assistants then participated in a pilot test in October 2003 where interviews and focus group discussions were observed by supervisors. The team conducted six interviews and five focus groups in Lushnja, a peri-urban district 1-½ hours from Tirana. Tapes of interviews were then transcribed, and the Albanian transcripts were translated into English and reviewed by the U.S.-based research team. Once the pilot test data had been analyzed in the U.S., instruments were finalized (see Annex C for copies).

Based on the analysis of pilot test data, the research team organized a second training in November, prior to the launch of the fieldwork. To help develop a common vocabulary, PHR*plus* staff also helped the research team develop a glossary of terms that appeared frequently in the transcripts (Annex D). Translators were encouraged to refer to the glossary to increase consistency of translation between individual translators and between transcripts.

Fieldwork was conducted over a three-week period in November-December 2003. The schedule was organized so that the research assistants had enough time to review and revise their notes from each interview or focus group prior to starting a new one. Every one or two days, research assistants were given time and access to computers so they could transcribe the tapes of their interviews. Researchers obtained written informed consent from respondents before conducting interviews or focus groups. Notes and transcripts of interviews and focus groups were handled as confidential documents throughout the study.

3.4 Data Analysis

The U.S.-based research team analyzed the data using domain analysis. This type of analysis seeks to create a systematic understanding of a cultural practice by describing and analyzing people's perceptions, attitudes, and experiences. The team created a preliminary coding scheme using broad categories or concepts to organize the data, corresponding to the instrument guides (e.g., types of payments, why payments occur, how payments occur, effects of informal payments, and reforms). A preliminary analysis of Berat data helped to identify trends and new coding categories that were then examined more closely as the team analyzed the other two districts' data. Researchers gathered written comments and reflections from Albanian team members and incorporated this into the analysis as well.

4. Findings

The findings are organized into six sections: Types of Informal Payments; Magnitude and Reasons for Variation; Why Informal Payments Occur; How Informal Payments are Made; Effects of Informal Payments; and How to Address Informal Payments. A discussion section and a section on implications for health policy follow.

4.1 Types of Informal Payments

This section describes how provider and public informants distinguished between different types of informal payments. In order to understand the motivation underlying the practice from the perspective of informants, it is important to determine the terms and meanings associated with informal payments, as they relate to the intention of the transaction. Findings are organized around categories that include:

- Albanian terms for informal payments;
- Gifts;
- Active soliciting or passive accepting;
- Cash and in-kind;
- Informal payments, tradition, and change.

4.1.1 Albanian Terms for Informal Payments

The direct translation of "informal payment" is *pagesat jo zyrtare*. *Shpërblimin nën dorë* is also used (under-the-table payment). Informants commonly referred to informal payments as *ryshfet* (translated most often as tip although sometimes as bribe) and *bakshish* (originally from Turkish, translated as tip or bribe). General public informants in Kuçova and Fier used the word *bakshish* less often. The words used for gift or present included *dhurate*, *peshqesh*, and *mikpritje*. Annex D presents a glossary of Albanian words used to talk about informal payments.

4.1.2 Gifts

Some of the criteria that seem to mark the distinction include patient intention and willingness to give, timing of the exchange, value of the amount exchanged, and whether the exchange was cash or not. These characteristics are described further below.

Patients' intention and willingness to give. Provider informants in all locations described the difference between gifts and informal payments based on the patient's intention behind the

transaction. Gifts are voluntary to show appreciation. But when the patient gives because he or she feels compelled, it is considered an informal payment. Generally, public informants also felt intention was important, as illustrated in this quote: *"When I give the money because I am satisfied with the service performed, that can be called a gift."* (Kuçova public informant)

Informants described how gifts make both the provider and the patient feel good, in contrast to the informal payment.

> *"The present represents something more civic, more spiritual, while the informal payment is a kind of an obligation for the patient, is a lowering of the image of the doctor, a detriment to his image. The present is something sincere, confidential, and is dignified as well." (Berat doctor informant)*
>
> *"Albanians in their tradition are well known for their hospitality and if a doctor comes to the home we will treat him with all we have…you would give him a hen or something else." (Berat public informant)*

Timing. Some public informants distinguished gifts as occurring after a service, rather than before. For example, a Kuçova public informant stated, *"[Given] at the end… it seems as if you are giving a gift. Whereas when I pay at the beginning, it seems as if I have bought his services. That is a kind of bargaining."* However, other respondents noted that gifts can be given before, and that other types of more obligatory informal payments can happen after, so timing is not a very sensitive or specific defining feature.

Token value. Gifts are symbolic and don't have as high an economic value as informal payments. Examples include a small token such as a coffee (or often the cash equivalent of a coffee), *raki*, a traditional Albanian alcoholic drink, or farm products.

Compared with Berat, doctors and nurses in Kuçova and Fier didn't define a clear distinction between gifts and informal payments. This may be related to their perception that money payments given to them are of nominal value, around 200 new lek[3] (about $1.82). Kuçova and Fier providers felt that not much true incentive could be derived from such a small amount of money, and that it is just a symbolic gesture whether it is cash or another form.

In-kind. Providers and general public informants stated that gifts were often in-kind. At the same time, many informants admitted that gifts could also be cash. This is discussed further in Table 1 and in a later section of the report.

Table 1 shows some of the characteristics that providers and public informants mentioned when describing a gift or an informal payment. It then shows how some of the attributes may apply to both types of exchanges, whereas others are more characteristic of one or the other.

[3] Informants sometimes gave prices in "old" Lek (prior to the 1964 devaluation) and sometimes in "new" Lek, often without distinguishing which currency they were using. 1,000 in old Lek = 100 in new Lek. At the time of the study US 1.00 = 110 new Lek.

Table 1: Gift versus Informal Payment

Characteristic or Attribute	Gift (dhurate, peshqesh)	Informal Payment (ryshfet, bakshish)
Given willingly	Usually true, although some people may feel they are obliged to give a gift for moral reasons (as described below)	From the providers' perspective it may be seen as given willingly, while more often patients feel forced or obliged to make informal payments in order to receive care
Fulfills a moral obligation or spiritual need	Can be true. Some people feel as though they are morally obliged to give something when they have received a service	Not usually
Gives patient pleasure	Usually true	More providers than general public respondents thought this was true.
Expresses respect, hospitality, gratitude	Usually true	Not usually, although some providers did say patients gave informal payments to express respect
Expresses satisfaction with the outcome	Usually true	According to the public, informal payments are usually independent of the patient's level of satisfaction with outcome, but providers sometimes believe informal payments express satisfaction
Given after service has been provided	Usually true	Informal payments can be given before, during, or after service is provided
Implies good provider-patient relationship	Can be true. Gifts are sometimes given to a provider who has a relationship with patient, but the relationship need not be pre-existing	Not usually. Some providers expressed belief that patients give informal payments to create a warmer relationship with provider. Patients did not express this belief, however.
Of token value	Most informants agreed that gifts are "symbolic" and of small, "token" value, though some said wealthier patients give more valuable gifts	Not usually. Informal payments were sometimes of low value in Kuçova and Fier, which may be why it was harder to distinguish them from gifts
In-kind	Often, though not necessarily. A gift can be cash, as in the patient who gives a doctor 1,000 (old) Lek and says to "have a coffee"	Not usually, though there are cases where large amounts of produce or goods are given as an informal payment (a bottle of grappa rather than a glass, kilos of oranges rather than a few)

4.1.3 Active Soliciting or Passive Accepting

Providers in Kuçova and Fier stated that, if unsolicited, gifts and informal payments serve the same function of expressing appreciation. This echoes the Berat providers in the sense that most providers insisted that they never demanded informal payments, although they accept payments when the patient insists on giving them. Providers mentioned the Albanian saying "even the King accepts gifts" as a way of explaining why they would not refuse an offer from patients.

In all areas providers feel that the patient would be insulted if they refused to accept something that the patient offered. Some providers described how, when they attempt to refuse an offer from the patient by saying is not necessary, the patient persists and forcibly puts the money in their pocket.

Providers feel it is less morally questionable, and not perceived as wrong by patients, for the provider to accept informal payments if it is not requested but given voluntarily by patients after the service.

> *"If the patient is satisfied with my work at the end of the examination and gives me something, why should I not take it? Bakshish is accepted by everyone. I would never behave in a way to imply my patients should pay, if they are to be examined. After 4 or 5 years I myself will be a retired person and I don't want to smear my reputation." (Kuçova doctor informant)*

Virtually no general public respondents raised the issue of feeling insulted if a provider did not accept their offer of an informal payment, but this issue was not directly probed. General public respondents did not independently bring up the idea that there is a moral difference between whether a provider demands a payment or merely accepts it when offered. See further discussion in the section on how people learn that they are expected to pay.

4.1.4 Cash and In-kind

Informants said that gifts and informal payments can both be either in cash or in-kind. In Berat, providers and general public informants described that if cash is given, they characterize it as an informal payment. Others observed that gifts can also be in the form of cash, and informal payments can be in the form of goods especially if the patient is from a village. In Berat, general public informants said that informal payments were limited almost exclusively to cash ("*Doctors do not accept anything else but money*") but a few respondents mentioned material goods such as dairy products or meat. Members of the public in Kuçova, and to a lesser extent in Fier, mentioned a wider variety of material goods that were given to providers as informal payments. Informal payments in the form of material goods seem to almost exclusively occur when the patient is from a rural area.

> *"The poor village man came to see the bone doctors with a bag of cherries in his hand. I saw him with my own eyes." (Fier public informant)*
>
> *"The doctors ask for food, especially from village people...Milk, eggs, lamb meat, or something else." (Kuçova public informant)*

Some provider informants said the former "village" custom of giving a gift such as eggs, oil, or other farm products is now changing to the form of cash. They explained that the market economy has influenced people to use cash in the place of goods, for both gifts and other types of informal payments.

4.1.5 Informal Payments, Tradition, and Change

Patients used the phrase "have a coffee" as they gave the money to doctors, couching the transaction with social graces and hospitality even if they do not physically sit together and have a coffee. In all areas this seems to be the phrase commonly used with doctors, though it is not clear whether it is used with nurses as well. This may be due to the hierarchy in services, and the greater social respect generally accorded to doctors. Usually patients gave small amounts of cash such as

1,000 old lek (perhaps roughly the equivalent cost of a cup of coffee) as they urged the doctor to "have a coffee from me."

Informants from the general public in Berat felt that treating the doctor to a coffee or other token gesture was a part of their cultural tradition, but they did not see cash payments currently being required in hospitals as having anything to do with tradition. Kuçova and Fier public respondents, on the other hand, were not so adamantly opposed to the notion that informal payments are part of Albanian tradition. Yet, members of the public in all three of the study locations generally felt that the traditional meaning of gift giving to health care providers as a sign of respect and appreciation has been corrupted over time into the current practice of requisite informal cash payments.

> *"My mother-in-law was hospitalized. We gave the doctor all we had…The doctor insisted to be paid more and he said, 'This is very little money. With this money I can only pay a cup of coffee. Other people give me 2 million lek.' Maybe other people had money to give…" (Fier public informant)*
>
> *"We can talk about tradition, maybe about the creation of this new type of tradition but we must not consider it as part of our culture. It is not our culture. There's a general opinion that people need to pay and that's it." (Fier public informant)*
>
> *"The most important thing is that you should pay the doctor, because he will never forget the face of someone who has not paid him, for the rest of his life." (Fier public informant)*

4.2 Magnitude of Informal Payments and Reasons for Variation

The second set of findings from this study describes informants' perceptions regarding the size, scope, and frequency of informal payments, and reasons why informal payments might vary. Most providers and public informants acknowledged that the practice of informal payments is pervasive. It should be noted that the public informants and providers openly described their own experiences and the experiences of friends and relatives in *giving* informal payments; however, most providers were hesitant about admitting the practice takes place in their own facility, or that they themselves *accept* informal payments.

The study informants described many factors that they felt were associated with the level of informal payment expected, requested, or given. Factors that seemed to affect the level of informal payments included patient, provider, and service attributes, as well as other contextual factors. The list in Table 2 summarizes some of the perceived reasons for variation in the amount of informal payment that is requested or paid, as described by provider and general public informants. Following the table, the report discusses some of these factors in more detail.

Table 2: Explanations Given by Providers and Public Informants for Variation in Informal Payment Amounts

Patient Attributes
▲ Economic status of patient (poorer people sometimes do not pay or pay less)
▲ Relationship with provider (if patient and provider are related or have pre-existing relationship, patient may pay less)
▲ Ethnicity (immigrants may pay more because less likely to complain)
▲ Whether the patient resides in locality of clinic (may pay less if seeking care where one lives)
▲ Political position of patient (patients who have political connections and/or know their legal rights are less pressured to pay)
Provider Attributes
▲ Qualification of provider (providers with more training, experience, good reputation, or a higher level appointment command higher payments)
▲ Specialist versus generalist (specialists command higher payments)
▲ Scarcity (if there is only one provider in the area, the payment may be higher)
Service Attributes
▲ Facility location (generally pay more at urban locations)
▲ Facility type (generally pay more at hospitals)
▲ Inpatient versus outpatient (generally pay more for hospitalizations)
▲ Specialty (surgery and obstetrics are more expensive)
▲ Amount of work the procedure or service requires of the health personnel
▲ Procedure complexity (more complex procedures are more expensive)
▲ Level of technology (pay more for higher technology)
Other Contextual Factors
▲ Economy: transition from planned economy to market economy has increased informal payments over time. Government revenues can't support salaries of workers. Also a general trend toward valuing money and monetary transactions more than before.
▲ District: payments seemed more pervasive and higher in Berat than in either Fier or Kuçova. May be due to service attributes such as higher level of urbanization, or other contextual differences such as level of social distance, familiarity of patients-providers.
▲ Social norms: over time, the status or prestige associated with saying you made an informal payment may be increasing, driving up informal payments.

4.2.1 Service Location (District, Urban-Rural)

Providers in Fier thought that informal payments were higher and more common in Berat and Tirana, while general public respondents in Fier felt that there were few price differences. Providers and general public in Kuçova were in agreement that prices were lower in Kuçova than in Berat and Tirana, mainly because Berat and Tirana are more urban. Interestingly, some public informants thought prices were higher in small cities such as Fier, than in larger ones such as Berat and Tirana, whereas other informants thought prices were higher in the larger cities, especially for people who were not from the city and not part of the city's social network (as discussed further below).

"In Kuçova the payments are very small. Over 60-70 percent of the patients do not pay… While in Berat, it is difficult to leave the hospital without giving informal payments." (Kuçova doctor informant)

"The informal payment in a maternity hospital or surgery ward in Tirana or Berat is quite different from the informal payments in Kuçova (where the level of informal payments is very low)… Kuçova is a really small town, and almost all the people know each other. The city has 10 or 15 specialists and all know us; therefore, we can't do [such] things, because we know each other." (Kuçova doctor informant)

Providers also explained that informal payments are lower in small cities because the level of health technology is lower and doesn't warrant informal payments. According to a Kuçova doctor informant, *"Here doctors only have a stethoscope and what can they do with a stethoscope, tell me?"*

4.2.2 Relationship with Provider and "Social Distance"

Some general public informants felt that in small towns or neighborhoods, providers are reluctant to directly demand payments from patients with whom they are acquainted. *"For example, I don't pay the doctor who works in the health center in my neighborhood, while when I go in the polyclinic I pay." (Fier public informant)* Perhaps more locally based, neighborhood doctors feel a greater degree of social accountability toward their patients than providers working in more anonymous situations in large cities. Hence, the fact that someone from a rural area or even a different city would be asked to pay a greater sum of money while in a large city like Berat or Tirana may be more reflective of social distance rather than geographic distance or assumptions made about "rural" versus "urban" people.

"I don't mean to offend anyone but in hospitals those who tend more to make informal payments are the village people…they come in hospitals and have this fixed idea that they must give something to the doctor. From my own experience none of the doctors has ever asked me to pay." (Fier public informant)

According to providers, villagers who come to the city for treatment are charged more than city dwellers because the villagers want more rapid service (the assumption being that they want to quickly get back home). Individuals from rural areas may also pay more because they are less familiar with what the payments for particular treatments "ought" to be. In addition, the villagers do not have personal relationships with the providers in the city, so are put under more pressure to pay.

"There is a kind of abuse by the doctors. In the moment they understand the patient is from the village, the doctors set forth other financial demands to them. The ones living in the city pay less." (Berat nurse informant)

"I have friends in the city and they tell me that [city residents] don't pay, while when villagers come for a visit they give more." (Kuçova nurse informant)

A Kuçova public informant suggested that doctors might be more likely to take money from Greek immigrants because they are unlikely to complain. This supports the argument that providers

are prone to demand informal payments from those outside of their own social network and to whom they would have less accountability.

4.2.3 Type of Service

Berat provider informants said that payments are nearly always made for treatments that entail surgery or are considered life-saving. These payments are higher than for preventive services. Informal payments are highest for complex or difficult services such as surgery, obstetrics/gynecology, and cardiovascular or liver disease. According to one public informant,"*It is known that the payments vary. The easiest operations have lower informal payment assigned…"*

Some informants thought that the amount of informal payment was related to the gravity of the illness: general surgery is thought of as more serious and frightening; therefore it commands higher informal payment. Likewise, births warrant a higher price *"for the fact that a new individual is expected to come to life."(Berat administrator informant)*

4.2.4 Type of Provider

Provider and general public informants said that general practitioners take informal payments, but in amounts less than specialized doctors. Doctors or surgeons with a higher reputation or more skills and training are thought to provide higher quality service and expect or are thought to require higher informal payments.

Some Berat doctors perceived that nurses receive more informal payments than doctors since nurses have more contact with patients, while other informants perceived that doctors were paid more than nurses. *"If the nurse works in the village, the patient pays for the injections, but gives less to her than the general practitioner…perhaps half the amount he gives to the doctor." (Kuçova doctor informant)* A few informants, especially from Kuçova and Fier, say that nurses are never paid.

4.2.5 Other Contextual or Environmental Factors

Some people felt that informal payments did not commonly occur prior to the 1990s. Providers who say that informal payments are not made claim that it is because people are still used to not paying for services (since they didn't have to pay during the dictatorship).

Several informants stated they think the amount of informal payments has been increasing over the past few years.[4] For example, a nurse from Berat said,"*Before they used to pay 1,000 lek for a visit while now they need to pay 2,000. For an appendectomy operation doctors used to ask 20,000 lek while they now ask 100,000 lek."*

A few providers described their perception that amounts of informal payments may be increasing due to gossip among patients driving amounts higher. They think some patients may "brag" to others

[4] Local inflation was high six to seven years ago (32 percent in 1997 and 21 percent in 1998), related to the civil disorder upon the collapse of financial pyramid schemes in the country. Since 1999, however, local inflation has been low, averaging about 3 percent per year (International Monetary Fund, April 2004: Statistical Appendix, Table 11, p. 203).

that they paid a certain amount, which is higher than they actually paid, causing the next patient to think they are expected to pay that same amount. The implication is that patients may get a sort of prestige from being able to afford to pay high amounts.

It is worth noting that some providers in all areas bluntly used the word corruption at times when talking about informal payments. Some also spoke of corruption occurring in other sectors and expressed the belief that this has influenced the growth of informal payments for health care.

4.3 Why Informal Payments Occur

The third category of findings discussed is perceptions and beliefs about why informal payments happen. Table 3 provides an overview of reasons given by providers and general public respondents for why payments occur. A few of the more salient beliefs are then discussed in more detail in this section, including: low salaries for medical personnel; the belief that health is precious and worth any price; patient desire for better service or to gain access to care; social pressure and lack of deterrents; and capitalism and changing values.

Table 3: Reasons for Informal Payments, According to Providers and Public Informants

Reasons why providers accept	Reasons why patients offer or give
▲ Financial problems, low salaries	▲ Recognition that providers are not paid adequately
▲ To have a better life style or a high standard of living	▲ To motivate the provider to provide more attention, better service (anything from "a little smile" or showing kindness, to spending more time with patient, providing more medications, or conducting more attentive surgery or medical care)
▲ Market orientation (health care is a market, people should pay)	▲ To "warm up" or create a closer provider-patient relationship
▲ To not insult patients, because patients want to give gifts or make payments	▲ To expedite or speed up care (e.g., when someone is from out of town and needs to get back)
	▲ To be sure supplies are available
	▲ Because you must pay or you will not be seen or receive any care (e.g., no choice)
	▲ For fear that substandard care will be provided if you don't pay (e.g., nurse may inject plain water instead of medication)
	▲ For a feeling of security (did all that it was in your power to do to achieve good health outcome)
	▲ Because of gratitude, appreciation; to reward the provider (this type of informal payment may be called a gift)

Note: All reasons were supported by both providers and patients except two that were mentioned by providers only: "To not insult patients…" and "To 'warm up' the provider-patient relationship."

4.3.1 Low Salaries for Medical Personnel

A low salary was the most salient reason given by providers for why they accept informal payments. Medical personnel feel that the government undervalues their work. Berat providers described frustration with the low salaries and perceived inequities in how doctors are compensated.

> *"Salaries of health personnel were slightly raised, but there are still problems in this regard, because someone who has finished university and someone else that has completed only high school are financially treated equally by the state. And they say we do the same job." (Berat administrator informant)*

As in Berat, providers in Kuçova and Fier felt their salary was too low, even with the recent increases given by the government. In all areas, providers expressed the opinion that patients are conscious that providers are underpaid by the government, and that patients make payments to supplement providers' income.

> *"People say: 'Doctor, take this 200 lek, I prefer to pay you, better you than the government, because the government doesn't give you anything, just a monthly salary of 20,000 lek.' This is the new concept introduced by the people to reward the work of the doctor." (Fier doctor informant)*

Many members of the public did say that doctors and other health care providers had to ask for informal payments because their salaries are too low. "*The doctor needs to feed himself." (Berat public informant)* However, some of the public informants thought that doctors have gotten too greedy and are getting rich at the expense of their patients. Further, many members of the public were indignant that they should have to pay informal payments at all since they pay into the state medical insurance.

> *"[Nurses] said that their salaries were low, and that they needed to feed their children. According to me, I know that we are in a transition period and that the situation will not get better by giving informal money. We must all pay [social] insurance, so that the doctors receive better salaries and do not need to ask for informal payment." (Berat public informant)*

4.3.2 Belief that Health is Priceless

Both provider and public informants cited a cultural belief that there is no substitute for good health. Thus, beyond the fact that informal payments may open the doors to access to health care, large payments are sometimes willingly given to ensure restoration of good health, a "priceless" commodity.

4.3.3 Patient Desire for Better Service

In some respects, members of the public felt that they, as a whole, are responsible for the practice of informal payments. In giving informal payments to health care providers for better service, they have "trained" the providers to expect informal payments from them. Over time, informal payments have become the rule rather than the exception.

> *"The doctor gets paid from the government and he shouldn't accept additional payments, although we have our own part of the fault. It is also our fault if we think to give them money for better service." (Berat public informant)*

Provider informants also perceive that patients willingly give payments so that they will get better attention and care. In fact, some providers said that when they themselves need care they make informal payments to ensure the best possible treatment.

General public informants described how they would offer informal payments to get a doctor to come to the house to check up on a patient. One informant mentioned how she had offered the doctor a glass of *raki* after he had made a house call, at which point the doctor declined but said he would accept a bottle instead.

Providers in Kuçova and Berat explained that the amount offered for the informal payment is so low they don't consider it to be an incentive or motivation. They acknowledged that some patients might think they could get better care by giving informal payments, but the providers insisted that patients received the same quality of care, whether or not an informal payment was exchanged.

Provider informants described how patients themselves sometimes set expectations of how much a certain service is worth, as described by a Berat doctor in the quote below:

> *"Patients utilizing these services (examinations) do feel that they are served better in terms of quality, and for that reason should pay more money. Because of the improvement in technology, since the examinations are long lasting and their running cost is high, the informal payments are increased too. Since there is no comparison between a simple X-ray and a scanner examination, the patient doesn't feel that he should pay the same for both examinations. The patient believes that the scanner examination is an important one and for that reason he should pay more."*

4.3.4 To Gain Access to Care

Many providers and public informants described cases where no treatment would be given at all if a payment were not made. In such cases, informal payments are made because there is no choice.

> *"They do not only pay the doctors but also the rest of the health personnel such as nurses or janitors. For instance the patient goes to the hospital and cannot find the medicines he is looking for, the nurse doesn't make him an injection, she*

delays or she doesn't help the sick person at all. In these conditions the patient is obliged to pay." (Berat administrator informant)

"If you go to the hospital the doctor doesn't touch you if you don't pay 5,000 lek. And this doesn't happen only in Berat but also in Tirana; if you don't pay, no one touches you." (Berat doctor informant)

"I have heard about cases, without mentioning names, when the patient goes to the specialist and has not paid for the first time. [W]hen he goes there for the second time [the doctor] offers him a perfunctory service...he does not pay much attention to him, he says 'I am busy come back later'." (Berat doctor informant)

4.3.5 Social Pressure and Lack of Deterrents

Another factor driving informal payments, according to some providers, is that doctors are being socialized by their colleagues and medical training to expect informal payments.

"The great professors of Tirana are near the ministry and it is these professors who determine these payments. The doctors from Berat and other cities just observe and learn from these professors. The Berat doctors after their specialization learn how much money these professors ask for and when they come here they behave like them. These doctors sometimes serve as "managers" of their professors during the period of specialization. Doctors from different cities learn from Tirana." (Berat administrator informant)

Some providers said that in cities the interaction between providers and patients is more impersonal, since providers don't necessarily know their patients personally on a day-to-day basis. This means that providers don't have a sense of being judged by the community if they receive informal payments. Public informants also mentioned that health personnel face no consequences for withholding services in order to get informal payments. A Kuçova public informant noted "*before, providers would get fired if they did not provide service to people, while now the cleaning lady doesn't clean the room if you don't pay her."*

4.3.6 Capitalism and Changing Social Values

Some providers in all areas spoke about capitalism as a factor driving informal payments, referring perhaps to a free market economy allowing people to choose services and pay according to their ability. An administrator in Fier attributed the practice to the capitalist system this way:

"In the socialist system, these payments were strictly prohibited and people used to reward the doctor by inviting him or her to lunch. In the capitalist system, money stands in the center of everything; it is the main point, the key of living. And people who we can consider smart ones, they pay or give money to the doctor directly, not the government, to protect their health. They (a gift and informal payment) are the same thing. Instead of buying me an outfit, which probably wouldn't even suit me, he or she gave me the money. But these are things offered by the people. People started to pay the doctors because they could afford it and because they were satisfied by the service provided." (Fier administrator informant)

Public informants often stated that the practice of informal payments has become more prevalent over time and that the cost of the payments has increased. Further, public informants in all three of the research locations, though more frequently in Kuçova and Fier, compared the current level of informal payments to the more restricted level of payments during the time of the dictatorship.

> *"Fifteen years ago I hospitalized my daughter in the Military Hospital in Tirana because she had burns all over her body. A considerable amount of blood and plasma was used for her cure. As a result the doctor accepted nothing from me; nothing at all! The only thing I wanted was having my daughter alive, but he did not accept anything. Given that my daughter was totally cured I wanted to give something to him, because he saved her life, but he did not accept anything. Doctors of that time were very sensible and human; shame on the today doctors; the today doctors leave you die if you do not give money to them ...." (Berat public informant)*
>
> *"When I was ill, during the time before democracy, when the agricultural cooperatives still existed, doctors came and did all they could. At that time they did not want a single penny, but now the doctor does not care, as the ones of those days cared." (Kuçova public informant)*

4.4 How Informal Payments are Made

A fourth area of findings for the study was the rich detail provided on the operational process of informal payment making. The research team asked informants to talk specifically about how informal payments are made. Questions were asked in both personal and cultural terms, so that informants would feel free to discuss their individual actions and personal experience, as well as commenting on general patterns of behavior they observed. The findings on this subject are organized around seven themes:

- Who is paid;
- How people determine what to pay;
- When to pay;
- Informal payments, official fees, and insurance;
- Role of brokers or "managers";
- Exemptions and price discounting; and
- How informal payments are used

4.4.1 Who is Paid

Informal payments made by patients and their families extend well beyond doctors to other health workers and hospital employees. Nurses may need to be paid to make sure the patient gets a room, or to have IV drips set up, or injections and medications administered. It was also mentioned that cleaning personnel get payment though amounts were not specified. Some public and provider

informants reported that it is an Albanian tradition to give something to the person who brings you good news; therefore, nurses rush to announce the birth of a child (especially boys, since families may be particularly pleased at hearing this news). Public informants in all three of the research locations reported paying even the guards at the front of hospitals.

> *"People will be obliged to pay. They need to start by paying the guard at the door. After they have paid the first guard they will need to pay the other guard at the other door. And so on until you will reach the doctor." (Kuçova public informant)*

Nurses are mentioned as sometimes taking payments on behalf of doctors. The patients sometimes asked nurses how much to pay the doctor.

> *"One of the nurses comes from the operating room, meets you and says: This doctor wants 30,000 lek, this one wants 30,000, the anesthesiologist wants 40,000 and so on; so she tells you how much the surgeon wants, how much his aide asks for, and if you sum all figures the total will be about 300,000 lek." (Berat public informant)*

In addition to nurses taking payments on behalf of doctors, some providers say that nurses are often given informal payments to keep for themselves.

4.4.2 How People Determine What to Pay

When communicating about informal payments, several provider informants said the patients ask what they owe the doctor or nurse. *"When a patient goes for a visit he asks the doctor how much does the service cost or uses the expression …'do I owe you something doctor?'" (Berat nurse informant)* Other expressions used by patients to talk about informal payments include: "*How much does it cost?", "How much was the tariff?"* and *"Please help me, for I will reward you."* The doctor or nurse will often answer directly, giving specific instructions on how much and who to pay, as mentioned earlier.

> *"When you ask how much it costs, the doctor tells you how much he wants for himself, how much the anesthesiologist wants, how much the nurses want, and so on." (Berat public informant)*

Public informants also reported that medical personnel directly ask for payments. Sometimes doctors tell patients exactly how much they should pay, while at other times a nurse might convey this information. Informants said that the process takes place in the open and is not seen as something that must be hidden.

> *"Most of the doctors ask for money themselves; they decide themselves the amount the patient needs to pay." (Fier public informant)*

Some provider informants thought that patients estimate how much to pay by asking friends, neighbors, and relatives based on their past experiences. Public informants confirmed that there seem to be some "informal" standard prices, which people in all three of the research locations said they typically learn from friends and family members who have had similar procedures. As one Berat public informant explained, *"Yes, there are standard prices. An appendicitis operation used to cost 70,000 lek (old) while now it costs 150,000 lek (old)."*

Table 4 summarizes some of the ways that providers convey to patients the need to make an informal payment, both directly and indirectly. Although the quotes are from public informants, most providers confirmed that these strategies are used and gave additional examples.

Table 4: How Providers Convey that Patients Need to Pay, According to Public Informants

Staff talk about their difficult financial conditions	The nurse said: "1,000 or 2,000 lek are not a big deal. Our salary is not enough…" (Fier) "When the doctor finishes the examination, he says 'Do you know that we live under market economy conditions?' So you have no other choice but just to give him the money, because if you don't give him the money he would say, 'Are you here to be examined or to talk?'" (Berat)
Leave money on the table, showing that others have paid	"The doctor leaves some money in his working desk, so that when the patient goes there to be checked, he is obliged to give money…With this gesture he tells you that you have to pay." (Kuçova)
Ask directly	"*Ryshfet* (tips) are flatly asked for by the doctor." (Berat) "They ask to be paid before the service provided. In the case I mentioned before when I told you about my aunt, they had asked her before the operation." (Fier)
Act in an indifferent or unfriendly manner with patient	"The doctors speak in an angry voice to you." (Kuçova) "They look quite indifferent, and try to give the impression that they are very busy." (Kuçova) "We understand from their reaction, when they are not satisfied you need to increase the amount." (Berat)
Ask "who is with the patient?"	"When the doctor saw us, he asked, 'Who accompanies the patient'? When he asked who accompanied the patient, he intended to ask who would be the persons to give the money. He took the informal payments and put it in his pocket." (Kuçova)
Withhold or delay care, pretend to be busy with other things	"The doctor wants 2,000 lek for the prescription, otherwise he will not give it to you…." (Fier) "[The nurses] don't ask directly, but if you don't put the money in their pockets, they don't come…or they come too late." (Berat)
Staff tell you there is no medicine, patient must buy his/her own	"They tell you to buy a large amount of medicines at the drug store because the doctor owns that drug store." (Berat)

Many Kuçova informants described how providers leave money out on the table in their office to indicate that a payment should be made, though Berat or Fier public informants did not mention this practice. Patients were frequently asked directly for payment in Berat and Fier, whereas patients in Kuçova felt that they were met with slightly less direct, yet still obligatory, demands for informal payments. Finally, while some provider informants agreed that medical personnel might withhold care until informal payment was made, other providers felt these were unwarranted fears held by patients based on rumors, and that doctors gave the same quality of care to patients whether they paid or not.

4.4.3 When to Pay

Several public informants mentioned advantages to paying in advance. For example, one informant in Fier thought that unless the patient paid the nurse in advance, the nurse would act like she couldn't find the patient's vein, hurting the patient's arm in the process. Other informants reiterated that payment in advance guarantees better service, and ensures that the medical personnel are more attentive and careful.

Considering hospital care, informal payments are commonly given during the treatment. At times the amount of payment is agreed on before the surgery, but the actual payment is after the surgery. One doctor informant in Berat explained that the "*timing of payment depends on how stressed and uncertain the patients are. Usually they pay in advance.*"

One public informant described how he was able to "trick" the doctors into treating his daughter without making any informal payment.

> *"I told them before the operation that I would give the money at the end of the intervention. When the operation ended, I bought a chocolate for all the doctors. Laughing, all the doctors said 'you played a trick on us. Thank you.' I said goodbye and left. But in reality they were expecting some money from me… There was nothing else I could make. Otherwise the doctor wouldn't operate on my daughter." (Berat public informant)*

Public informants also thought the timing of an informal payment could affect the overall amount paid, as well as the treatment outcome. For example, one public informant cautioned that women in labor should always deal with the shift doctor right away, rather than waiting to make the informal payment until the baby is born; otherwise the doctor might provoke an early birth so that the baby is born during the doctor's shift and he can get the informal payment. Paying all the shift doctors and nurses, rather than just the ones involved in the actual delivery, increases the overall price paid but also may be less risky for the baby. The public reported how providers can delay adequate treatment and sometimes compete with one another for the informal payment, with a negative impact on access to quality care.

> *"When my baby was born, the nurse came close to me saying 'Wait until the other doctor goes away, because if she will be present, she will ask for her share as well.' Due to this reason, they made me wait until I lost consciousness…they knew I was rich; the doctor waited until the other doctor came; she wanted to share the money with the others, leaving me in a very difficult situation, and the life of the child was in danger. They were wondering whether the baby would live or die, and my life would be in serious danger…I had the impression I was dying, while they were discussing who would be the one to take the money." (Berat public informant)*

4.4.4 Informal Payments, Official Fees, and Insurance

Berat informants described "unofficial fee lists" that are sometimes shown to patients before treatment. While the research team did not actually see such a list, these may in fact be official price lists for procedures, as are established for some uninsured patients for example, or for ancillary tests

in hospitals. Providers may be pocketing the official fees rather than submitting them to the facility, as some informants hinted. However, this is not clear from the data collected and would require further study.

Kuçova and Fier providers also mentioned they feel that patients do not always understand that they must pay some official fees and mistake this for an informal payment.

> *"To tell the truth I have not asked the ones with no insurance to pay 2,000 lek because I have not been sure if they would understand that this money is related to formal payments." (Kuçova doctor informant)*

In all areas, providers said that some patients make informal payments whether or not they are insured. However, some Fier providers mentioned that rural people are less likely to be insured than urban people, and therefore more likely to make informal payments.

> *"Because people from the cities are quite aware of [insurance benefits], they hand you the insurance booklet… insured people are aware that they don't have any financial obligation towards the doctor, but in some cases someone pays because he or she wishes to. While village people find it very difficult to pay their annual insurance and receive an insurance booklet…" (Fier doctor informant)*

4.4.5 Role of Brokers or "Managers"

A small number of Berat informants mentioned that in hospitals, a person described as a "manager" or "broker" may collect payments and act as an intermediary between the doctor and the patient. The use of brokers was described in connection with very busy doctors, especially surgeons. Brokers were described as not necessarily someone in official positions as part of the health system (i.e., not necessarily staff in the facility). Those informants who discussed brokers did not mention their presence in other settings aside from hospitals.

> *"In our hospitals it is a common occurrence to have "managers"...The doctor does not appear on the scene. In Berat, for example, there is a "manager." He tells you how much an operation costs. He fixes the amount of money and he asks for it. There is no need for the doctor to ask for the money." (Berat public informant)*
>
> *"[T]here are brokers who take care of these things. They are like managers…If there is a broker (he prefers the term manager) these payments are made before." (Berat doctor informant)*
>
> *"When you go to the hospital, someone will approach and will ask you, 'What is your problem? I know the doctor; we will give him 100,000 lek (old) and solve this problem." (Berat public informant)*

(While only a few public and provider respondents in Berat described this practice, one public informant from Kuçova also suggested the use of such brokers during a focus group discussion, although other participants in the group seemed to disagree about their existence/presence.)

4.4.6 Exemptions and Price Discounting

Rural providers in Kuçova and Fier believe that the poorest and elderly do not make informal payments, and that the amount anyone pays is very nominal for visits to the doctor. More than in Berat, providers in Kuçova and Fier emphasized that they avoid accepting informal payments from vulnerable groups.

> *"I could not ask for money from a poor person. If I accept his money, I do not know is he would have more money for tomorrow. I would never put a patient into a very difficult situation or make him borrow money from the others. Even when they have insisted that I accept the money, I have refused. I know that a patient does not stay in hospital for one or two days. He would stay there for 10, 15 or 20 days. Can the patient afford to give all this money for such a long time? He will give money not only to me but to all medical staff that work with three shifts…." (Fier nurse informant)*

Kuçova and Fier public informants confirmed that there are some situations where patients are exempted from informal payment. In addition, there seems to be some sliding scale of informal payments in Kuçova according to the ability of the person to pay. This was not seen in either Berat or Fier. The level of informal payment also seems to be somewhat dependent on how well the individual is acquainted with doctors and hospital staff.

> *"A friend of mine had asked the doctor how much an eye operation cost. The doctor told her that it cost over 10,000 lek (new) but the doctor would make a discount for her because he knew she didn't have money." (Kuçova public informant)*

Informal payments for operations in Kuçova and Fier are sometimes given in installments. The Berat public informants did not mention these types of accommodations.

Although some public and provider informants, especially in Kuçova and Fier, described practices of exemptions and price discounting to protect the vulnerable, many informants had stories of very poor patients who were still expected to make informal payments. Providers and general public in all areas are particularly concerned that the poor and pensioners must borrow money to pay for treatments, diagnostics, and surgeries, which can be economically catastrophic. For example, a nurse described a situation she witnessed while not on shift at the hospital, but waiting for a relative:

> *"[A] person whose trousers were full of patches came in. He was holding a baby in his arms. At the first moment the baby looked as if it was dead. There was something on his face... While we were waiting…the emergency doctor came. He said: 'Now you should give me 50,000 lek. I will be back in a while. During this time you can find the money. It is not necessary to be a big sum of money. We can talk later on for the rest.'… I do not know what happened later... I felt very sorry because the baby looked as if it was dead…Another doctor was there at that moment. He was very mad with the way the emergency doctor behaved, so he decided to operate on the baby himself." (Fier nurse informant)*

Some public and provider informants thought the amount patients pay depends on their income level, but also on the value they place on health (the importance of the service and importance of being healthy). For example, a midwife in Berat thought wealthy people give money lavishly after the birth of a son. Other informants felt that everyone pays similar amounts regardless of their income, and that this is a particular burden to the elderly and poor.

4.4.7 How Informal Payments are Used

The research team asked questions about perceived uses of informal payments. Public and provider informants said that providers use the money personally for themselves and their families to supplement their salary, and did not describe any cases where the payments were used to improve health service infrastructure or supplies. Some public informants described how improved technologies over time (such as diagnostic equipment) made the patients perceive they should pay more for the services, but that the payments themselves did not actually go to making improvements. Other public and provider informants described how making informal payments to providers reduces the amount of money that should go to supporting and improving the services (presumably because the patient is making the informal payment in lieu of official user fees).

4.5 Perceived Effects of Making Informal Payments

The fifth category of findings focuses on perceived effects of making informal payments. The researchers asked informants to describe the perceived benefits or drawbacks to informal payments and to suggest any other consequences of informal payments that seemed important. Most informants, especially members of the general public, had a hard time thinking of advantages. This section presents the *perceived* advantages and *perceived* disadvantages of making an informal payment, according to provider and general public informants.

(Note: This section does not aim to analyze or examine all of the various potential effects of informal payments or the practice of making such payments. Rather it provides an overview of informant responses vis-à-vis their personal *perceptions about the effects of informal payments*. The subsections below categorize the *perceived* effects of informal payments as reported by public and provider informants, and not the authors' analysis of potential effects of informal payments. The discussion section provides the author's interpretation about potential effects of such payments.)

4.5.1 Perceived Advantages

4.5.1.1 Access to Services and Improved Quality of Care

Informal payments are perceived as a needed motivation to get medical personnel to perform their duties. Providers described cases where they had witnessed patients or relatives experiencing delays in care due to the lack of informal payments. Thus, informants perceive that one advantage of informal payments is to avoid delays in accessing needed care.

> *"A woman had an appendicitis operation and she was suffering a lot from the pain. She told the nurse she needed tranquilizing but the nurse did not help her.*

It was only after she put 2,000 old lek in the nurse's pocket that she gave her the sedative." (Kuçova nurse informant)

Public informants also perceived that quality of care improved when informal payments were made. Patients making informal payments would get IV solutions and medications that otherwise might be withheld. Patients felt that those who made informal payments would be operated on with more care and attention. (As mentioned earlier, provider informants typically stated that although patients may view informal payments as a way to get better service, the same quality of care was given whether the payments were made or not.)

4.5.1.2 Closer Patient-Provider Relationship

Provider informants reported that they felt the relationship between providers and patients was improved through informal payments. Berat provider informants described developing a closer, more personal relationship with patients who give informal payments. For patients who need ongoing care, this was perceived to be especially influential.

"They get to know each other while they pay and get paid. This warms up the relationship." (Berat nurse informant)

Yet, often the public informants held opposing views. Members of the public in all of the research locations felt that the informal payments had no positive effects on their relationship with the provider beyond possibly improving the quality of care and/or ensuring that any care was received at all. Also, public informants stated that, particularly in the case of chronic conditions, they felt compelled to give informal payments to the doctor to ensure that they would not be turned away the next time that treatment was required.

"The generality here is that the doctors do not even touch you if you don't give any money, and when you see that the doctor does not take care of you, but leaves you waiting while you are sick, of course you have to pay them." (Berat public informant)

"All the other patients said that if you did not pay the nurse she would make the injection with water, or would not appear at all." (Berat public informant)

"They refuse you when you pay a small amount and that is why you need to pay more." (Berat public informant)

4.5.2 Perceived Disadvantages

Both public and provider informants were able to list many more perceived disadvantages than advantages, as outlined below.

4.5.2.1 Erosion of Professional Image, Respect, and Trust

Berat providers felt demeaned by accepting informal payments. Most provider informants were concerned that the professional image and trust by the public in health providers was seriously damaged by the existing informal payments.

> *"It has negative effects for the doctor, because soon after he will get the money from the patient he [the patient] will tell everybody that he gave money to the doctor. This is a negative effect for the doctor's reputation." (Berat doctor informant)*

Providers in Kuçova and Fier agreed. They said they would be embarrassed to be gossiped about by neighbors and friends if they were soliciting informal payments, and said that their reputation and standing in the community were more valuable to them than these payments.

> *"These payments make me feel like I was the 'servant' of this patient. It feels like the patient is feeding me. I provide health service and I don't like to take money from someone who doesn't have shoes to put on." (Kuçova doctor informant)*

Some public informants also mentioned feeling shame or humiliation from making an informal payment. They talked of how medical personnel only "look you in the hands" (to see what you are able to pay) instead of treating the patient with respect.

4.5.2.2 Inducement of Unnecessary Medical Interventions

Some informants, particularly administrators, described concern about how informal payments can adversely influence a doctor's choice of treatment for the patient.

> *"Pregnant women can have ultrasound examinations free of charge, which determine if they...will need to have an operation. Doctors tend to dramatize the situation and decide to have an operation instead of a normal, natural delivery because for difficult interventions they take more [informal payments]." (Berat administrator informant)*
>
> *"There are very 'wise' doctors who prolong a very simple nose operation which normally lasts 2 minutes into 15 minutes and get paid 15,000 lek." (Berat administrator informant)*

4.5.2.3 Discontinuity of Care or Poorer Quality Care

Some public informants said that individuals without the resources to make informal payments have to visit different doctors each time they need treatment to avoid being remembered as a non-paying patient. One provider informant said that patients who wanted to avoid payments would switch from provider to provider. Informants described a pattern whereby some uninsured patients bypass general practitioners and go straight to the specialists to save time and informal payments.

Provider informants felt that the practice of relatives handling the informal payment on behalf of the patient (indicating that family members are entering areas where they were previously not allowed) created clinical care problems. Some informants felt that the leverage gained by patients through making payments to the provider can actually compromise the quality of care they receive. As one Berat informant explains:

> *"Let me take the case of an operation as an example…In the case the doctor is paid [informally]… there will be not 2 or 3 persons but 10 persons in the patient's room. There will be continuous going in and out, the patient will even ask for things not allowed for his health, because of the 'affinity' created between the patient and the doctor, and the latter will feel obliged to offer some 'privileges' to the patient…[such as] requests for different kinds of drugs…" (Berat administrator informant)*

Members of the public in all the research locations perceived that the idea of "no payment, no treatment" was an experienced reality. To these informants, the main disadvantage to making (or not making) an informal payment is the potential that they will not be treated if they cannot pay.

4.5.2.4 Risk of Harm to Provider

Some providers perceived that accepting an informal payment resulted in additional pressures from the patient and/or their family. For example, a nurse-midwife said she feared accepting payments prior to assisting childbirth because if the family had paid and something went wrong, she would be blamed and possibly physically harmed.

> *"If something goes wrong, the family members will kill you, because they will say I have paid you 500 leks, why have you not done your job properly?" (Berat nurse informant)*

Some doctors also said they feared the reactions of family members who might become angry if there were quality problems after having made the informal payments.

4.6 How to Address Informal Payments

Finally, providers and the public were asked what should be done about informal payments. Public and provider informants were generally not aware of many efforts to address informal payments at present, but had several suggestions for future actions, including stronger government regulation and control, greater media coverage and information, and actions related to raising salaries, strengthening official fee systems, and creating community boards. These ideas are discussed in more detail below.

4.6.1 Regulation and Control

Members of the public generally believed that the state, particularly the Ministry of Health, should be responsible for regulating informal payments. Public informants thought that laws should be put in place and enforced to see that doctors refrain from asking for bribes. Informants believed

that with the social insurance system, doctors should not be asking for and accepting informal payments. Public informants thought controls and sanctions were needed to assure that doctors stopped asking for informal payments.

> *"If the wages of doctors are increased, they should be accompanied by administrative measures. The medical staff should never again think of taking informal payments or bribes, because he/she will otherwise lose his job. Only by increasing wages and by strengthening the control can this phenomenon be done away with." (Fier public informant)*
>
> *"We agree that doctors should have a higher salary, but a kind of control on their activity is needed as well. I will go to the doctor because I am obliged, and the doctor should serve me, without trying to find direct or indirect ways to ask for money." (Berat public informant)*

While some informants in supervisory positions did report efforts to verbally discourage their staff from taking payments, many provider informants confirmed that there are currently no sanctions against providers who accept informal payments, and they acknowledged that patients feel they have no recourse in the matter.

Members of the public agreed that they had no way to make a complaint about informal payments, rendering them powerless to refuse participation in the current system. Some informants mentioned seeing boxes for patients to submit complaints and suggestions, but did not see these measures as having any effect. An informant suggested that the Doctor's Association in Albania should be strengthened to enforce laws by implementing sanctions and investigating complaints by patients.

4.6.2 Greater Media Coverage and Information

Kuçova and Fier public and provider informants had heard some media stories exposing doctors who solicited informal payments. Some informants described posters in institutions meant to discourage *bakshish* (tips, bribes), although these were not seen as effective. Provider informants said that "sensitization" campaigns through TV, newspaper, and other media would be needed so that the public would be more informed about the health insurance scheme and to change the "mentality of the patients" who are seen as driving the occurrence of informal payments.

4.6.3 Raising Salaries

Both provider and general public informants thought that an important step toward eliminating payments would be raising salaries. Informants felt that if doctors' salaries were higher, they would no longer need to ask patients for money. At the same time, many providers pointed out that raising salaries alone would not be enough, and controls are needed (as described earlier) to detect and punish those who continue the practice.

4.6.4 Official Fees

Among members of the public in Kuçova and Fier, there seems to be greater support for uniform, official fees set by the government for particular health services and operations than there was in Berat. This support was not unanimous, however, as some respondents worried that providers would continue to ask for informal payments on top of the official fees.

> *"I think there should be fixed tariffs like in the private sector. What is happening to the governmental services is a paradox; the doctor takes his salary and still wants money from patients." (Kuçova public informant)*
>
> *"The government should fix tariffs for every service and have a list for us to see." (Kuçova public informant)*
>
> *"At present the state does not take any money for some services, but the doctors do. In future, if the state will asks us to pay official fees, then the doctors will ask for twice as much. May God, that the state will never fix such fees." (Kuçova public informant)*

4.6.5 Community Boards

The research team probed informants specifically on the feasibility and acceptability of community health boards as a way to increase accountability. Berat provider informants generally approved of the idea of having community boards, but informants felt that these should be voluntary and not paid positions and steps should be made to ensure there was no corruption associated with having a community representation post. In Berat and Kuçova, some providers expressed doubt that community members had the education or social standing to influence informal payments. However, many also supported the idea of having community boards which, given the appropriate background and knowledge, could help represent community issues and experiences that others in the health system may not be aware of, and increase accountability by alerting authorities.

Informants from the general public had mixed responses regarding community boards. Some informants favored having a venue where the public's "voice" could be heard on governance issues. For example, one Fier informant said, *"I think [community boards] will have a positive influence if they would care for the community problems, if they could hear our voice…"* However, most informants thought that the responsibility for tightening regulations and bringing an end to informal payments in the health care system ultimately rests with the state.

5. Discussion of Findings

This study adds new insights and details regarding the presence and practice of informal payments in a transitional economy country like Albania. This includes insights such as reasons for the variation in informal payments across populations and care settings; how the concept of "social distance" may influence the spread of the practice; ways of categorizing informal payments that can help us see where they fall on the spectrum of acceptability; and how the consequences of informal payments are understood (or not understood) and valued (or not valued) by different participants in the health sector. This section discusses some of these insights in more detail, while the next section of the report describes the implications for health reform.

5.1 Types and Variation in Payments

The evidence from this study suggests that the practice of informal payments for health services is especially pervasive in large towns and cities, and higher amounts seem to be requested from villagers who go to cities to seek specialized care. Informal payments are less common in areas where there is greater social cohesion, including rural areas and smaller urban communities.

The community ties between providers and residents in rural areas and smaller urban communities seem to deter informal payments, both because providers would be embarrassed or feel loss of professional reputation if people were to know they were accepting informal payments, and because it is common to exempt from payment people who are well known to the provider. In addition, there is less medical technology available in smaller urban or more rural communities, thus there is less benefit (in terms of access to quality services) to be derived from making an informal payment.

As seen in other regional studies, Albania informants described informal payments more often in the setting of inpatient care, particularly surgery, childbirth, and gynecological care. Informal payments in Albania appear to be higher for providers with more qualifications (e.g. professors) and better reputations. Albanian providers are more likely to report accepting payments *after* service was provided, whereas general public respondents were likely to report having given the payment *before or during* treatment.

5.2 Official versus Unofficial

For the general public in Albania, there seemed to be some problems distinguishing official from unofficial payments. At times people reported being told they had to pay an "official"charge, but that they could choose whether to pay the provider directly or make a special trip to the office. Often people preferred to pay the provider directly, either for convenience or because they felt a direct payment would motivate the provider to give better care. Many respondents identified official payments as those accompanied by an "invoice" (receipt). Where they did not receive an invoice, people assumed that the funds were going into the provider's pocket. Finally, some informants reported seeing "unofficial price lists" which might actually be official price lists for non-insured

patient user charges or insured patient co-payments. The researchers observed that policies regarding co-payments or exemptions for insured patients were not really understood and may not be uniformly applied.

The evidence from the study suggests that, in addition to informal payments, there is probably some amount of inefficiency (lax enforcement of collection policies) and possibly even fraud within the system of official charges in health facilities. This problem may need to be studied further to identify appropriate interventions.

5.3 Gifts versus Informal Payments

The Albania study provided insight into the definition of gifts versus informal payments. First, most members of the general public noted a difference between gifts (*dhurate*, *peshqesh*) and tips or bribes (*bakshish*, *ryshfet*). When asked to describe the words used to talk about informal payments, the general public used the words *bakshish* and *ryshfet* (tip, bribe) but rarely used the words *dhurate* or *peshqesh*. While providers also commonly used *bakshish* and *ryshfet*, they were likely to refer to unofficial payments from their patients as gifts.

In Albania, one word for "tip" *(bakshish)* can be used in the American sense of a voluntary gratuity to a service provider, but also can be used as a synonym for bribe. Another confusing factor is that a tip can refer to informal payments given before, during, or after treatment. This is important to know for future quantitative studies of out-of-pocket expenditures, so that questions can be asked to gather information about all types of payments: official fees; cash tips and bribes; in-kind informal payments; gifts and presents.

Gifts are seen as voluntary, token expressions of sentiment, and this is perceived as less troubling than when informal payments are expected or demanded by providers as part of a health care transaction. Gifts are made to reward a caregiver for being the bearer of good news or because the patient is grateful for having received a good health outcome. *"When a baby boy is born, we give the midwife 10,000 lek (old), because in Albania we love to give birth to boys…We are really happy in cases when the baby is a boy, and it is because of this feeling … that we give money to the person who makes the announcement." (public informant)* However, providers and general public respondents did not always seem to have the same perceptions about when an informal payment was truly a gift, or when it was a bribe or unofficial fee. The "have a coffee" informal payments in Albania were often perceived as an informal payment but also motivated at least to some extent by a traditional desire to express appreciation. In Kuçova and to some extent Fier, it was difficult to distinguish small cash gifts from other types of informal payments.

5.4 Reasons Why Payments are Made

Factors influencing informal payments in Albania included low salaries of health staff; a belief that health is extremely important and worth any price; desire to get better quality care; fear of being denied treatment or missing the opportunity to get the best outcome possible; and the tradition of giving a gift to express gratitude. Some other reasons given for the rising prevalence of informal payments were the lack of deterrents, social norms influencing providers, and the growth of capitalistic values in Albanian society. These are discussed in detail in the findings. The most salient belief of both provider and general public informants was that the practice of informal payments was caused by low government salaries paid to providers. Whether or not these beliefs are based in fact, it

will be important to incorporate the beliefs into any behavioral change strategies that are proposed to complement systems strengthening activities in the health sector.

The public and provider informants in Albania often described more than one reason for any particular example of informal payment exchange. The reasons and context of giving and receiving informal payments is a complex social encounter. Both providers and patients go through a process of interpreting the expectations of the giver and receiver at the time it occurs.

5.5 Process

This study provides the most detailed understanding to date of the process of informal payments, including who receives them, how people determine what they are expected to pay, and other details. Several findings were surprising. First, the role of unofficial "managers" in brokering informal payment deals between medical providers and patients was not previously known. While the findings only showed evidence of people encountering "brokers" in hospitals in Berat and Tirana, it illustrates an unexpected level of institutionalization of informal payments. In establishing bureaucratic controls and changing procedures to strengthen health institutions, planners should be aware of the role of brokers in the current informal payment process.

The researchers found some evidence of informal payment discounting based on ability to pay in Kuçova, but not in other areas. More often, respondents reported that informal payments were negotiated upwards as patients realized (by observing the facial expression or manner of the doctor) that their initial offer was too low. This finding is important because it shows that the informal system is not automatically providing safeguards for the very poor and vulnerable populations.

Finally, the study findings show that the interaction between patients, relatives, and various personnel at the many service delivery points is complex. As patients navigate the system, they seek information from other patients, friends, and relatives to try to establish who and what they need to pay to get proper attention, or any attention from personnel. Patients must read indirect clues from providers, in addition to, in some cases, dealing with brokers outside the health system or nurses to determine amounts to pay. Patients experience much ambiguity and uncertainty. When directly told they need to pay, they also don't feel certain about which are official fees (from the posted fee list), and which are informal payments. Many doctors feel uncomfortable interacting with patients because they don't want to appear to be soliciting informal payments.

5.6 Consequences

For the most part, Albanian informants had negative attitudes toward informal payments and could offer few advantages or benefits. Even providers, who were quick to rationalize the process as something patients want, and who one might think have the most to gain, could think of few benefits.

Public informants want the practice stopped because it is unfair and abusive, hurts the poor and vulnerable who cannot afford to pay, creates uncertainties and anxiety during the care-seeking process, and corrodes the patient-provider relationship, as doctors look "only at your hands." Providers would like to see the practice decrease because it harms their professional reputation, subjects them to social sanctions (ostracism or gossip), and is demeaning. Most providers indicated that they would prefer not to be in the situation of accepting informal payments. *"We are losing everything, no one respects us, we are losing our humanity, all the values we used to have." (Fier*

nurse informant) Most providers believe that informal payments are undermining the health care system and need to be stopped.

At the same time, health is seen as a "priceless" thing in Albanian culture, and people are willing to pay to gain access to care and for the prospect of better service. The public feels uncertain about how informal payments influence their care and they pay in the hope it might lead to better health outcomes. Some people stated that they would find the money however they could, even if it meant going into debt, to make the necessary informal payments. People also expressed feelings of responsibility for the health of family members and relatives, and this may continue to drive Albanians to make informal payments to avoid feeling guilt if their relative doesn't recover. Both provider and public informants commonly discussed their concern about the vulnerability of the poorest citizens, such as pensioners, to the demands of informal payments.

6. Implications

Most informants in this study saw informal payments as a serious problem that should be addressed through health regulation and institutional reform. They were eager to see their government try to tackle this issue and reduce informal payments.

At the same time, the current system provides advantages for some people. For example, physicians and nurses may currently earn informally a much higher salary than they would be able to earn even in a well-financed public system, and patients are able to get some assurance and peace of mind that they are able to access and receive quality services. So while there is general agreement that the current practice has problems, there are individual motivations to continue informal payments. This presents a challenge for addressing informal payments. As researchers in Poland suggest, "In a system where both physicians and patients have come to understand the advantages of informal payments, any change therein may require many attitudinal adjustments" (Chawla, Berman, et al. 1998). In addition, the practice of informal payments varies across the populations and locations studied, suggesting that it may not be easy to agree on the direction or content of interventions.

Specific implications of study findings for health reform and health system strengthening include:

1. Variation in attitudes and perceptions makes it difficult to create a common policy reform agenda on this topic. Focusing on the most harmful effects, and targeting the most vulnerable populations, may be one way to gain consensus.

2. Insufficient provider remuneration is the factor most frequently cited as motivating informal payments, and should be addressed.

3. Informal payments are now one of the only ways Albanian patients have to make sure health providers are being held accountable. Alternative accountability structures may help reduce informal payments.

4. Both insured and uninsured patients are making informal payments. The practice of informal payments may be reducing public willingness to participate in the social insurance system.

5. Interventions to address informal payments cannot easily separate or ignore gift giving, although the effects of gift giving on provider behavior and accountability are not yet well understood.

6. People generally look to the state to end informal payments, but some also see value in community participation to enhance accountability. Getting ordinary citizens involved in oversight or transparency initiatives may be a useful complement to regulatory and bureaucratic reforms.

These implications are discussed in more detail below.

1. Variation in attitudes and perceptions makes it difficult to create a common policy reform agenda on this topic. Focusing on the most harmful effects and targeting the most vulnerable populations may be one way to gain consensus.

In Albania, high officials have acknowledged that informal payments exist, although several have commented that they believe most of these payments are voluntary gifts (Vian 2003). This study provides some evidence that this view is not shared by the general public, or by many doctors and nurses. There were also differences in how providers and the general public viewed informal payments. For example, general public informants were more likely to see informal payments as forced, while providers thought patients were making voluntary informal payments.

High-level policy support for reforms usually requires involvement of a strong coalition of stakeholder groups who see common interests to be achieved through change. Given some of these differences in perceptions, it may be hard to create a common agenda.

Community-provider participation in problem solving may be one method to assist in coalition building. Efforts should be coordinated across sectors, as unofficial payments are considered to be pervasive in many sectors of government, not just health. Interest in reform can also be strengthened through educational and advocacy activities. This kind of dialogue can be started during the process of disseminating the study findings.

The policy reform agenda on informal payments should also try to focus on the most harmful effects of informal payments and include strategies to protect the poor and elderly who live on a meager income. This approach will make it easier to reach consensus, as most informants in the study agreed on the need to provide protection to very vulnerable groups. For example, rural patients seeking care outside their villages are especially likely to have to make informal payments.

2. Insufficient provider remuneration is the factor most frequently cited as motivating informal payments, and should be addressed.

Low salaries were mentioned as a motivation for providers to request or accept unofficial payments. Public informants also frequently mentioned inadequate salaries as a reason for making an informal payment, because they felt that otherwise physicians and nurses would not be motivated to work. This study was not able to document actual compensation to health workers or evaluate the adequacy or fair distribution of salaries and wages among different categories of personnel. Information on this topic would be very helpful to evaluate alternative approaches for addressing this motivation behind informal payments.

From a political perspective, any policy reform agenda that is developed is more likely to be supported by physicians and nurses if it includes actions to increase remuneration. With or without salary increases, behavior of community members may be influenced through a greater understanding of how providers are paid, salary differences among types of personnel, and other details about the fairness and adequacy of public sector provider payment and employee benefit policies.

In the short term, system strengthening activities could focus on increasing the financial and performance accountability of the official fee systems already in place in Albanian hospitals. The experience of Tirana Maternity provides an example of some of the steps involved. Though no formal evaluation has documented whether the hospital has successfully decreased informal payments, Tirana Maternity has reported success in increasing patient utilization while also increasing revenue collection. Current Albanian regulations allow hospitals to retain revenue and use it for salary supplementation, as Tirana Maternity has done to increase physician salaries by four-fold (Vian

2003). Another potential strategy for increasing financial accountability in fee systems is improving systems for cash collection and receipts. One study showed that networked cash registers can provide a high return on investment while also increasing patient and staff satisfaction (Stover 2001).

Longer-term changes may also be necessary, especially (according to the provider respondents who were interviewed) to increase official financial motivation for specialists such as surgeons. It is important to first document the existing salaries of all classes of health care workers, and to gain consensus on the true marginal cost of government-sector (or insurance-paid) labor. Some of the interventions considered in other countries have included reducing the number of government staff (to increase average pay per staff), allocating more money to the health sector for personnel salaries, changing payment systems to link compensation to performance, and developing decentralization strategies to allow lower-level managers more discretion in staff motivation and performance decisions. While it is beyond the scope of this report to analyze these options further, change is unlikely without cooperation from Albanian physicians, nurses, and other medical professionals.

It may take some effort to persuade Albanian clinicians that it is in their interest to advocate for policy change in this area, rather than simply accepting informal payments as a way to increase salaries. Yet, this study provides hope by demonstrating that many physicians and nurses do feel conflicted about informal payments and wish they did not have to accept them. These perceptions and attitudes can be built upon to create effective advocacy for public policy change.

3. Informal payments are now one of the only ways Albanian patients have to make sure health providers are being held accountable. Alternative accountability structures may help reduce informal payments.

Patients turn to informal payments to ensure accountability because they no longer trust that public servants are held accountable through any other means. This suggests that efforts to strengthen accountability in other ways, such as through legal or regulatory reform or information, education, and communication strategies, may reduce the practice of informal payments.

Before considering interventions, it will be important to map out the thought processes that providers and patients have at each step of the client flow. This could be used to initiate facilitated discussions for joint problem solving and building trust. The entrenched patterns of interaction will not disappear without intentional measures that strengthen accountability between providers and the public, as well as accountability among providers. Without trust in the system, some patients who have financial means may want to continue to pay to "guarantee" good service, and some doctors may also have incentives to continue to accept informal payments.

This study also highlighted important discrepancies between providers' perceptions and public perceptions about the effects of informal payments on quality of care, and why these payments occur. These qualitative research findings can be used to develop approaches for improving interpersonal communication and accountability during service delivery, as well as supportive supervision to reinforce this. In addition, the findings can inform the development of civil society approaches such as supporting patient advocates and community-provider committees. Advocates could particularly help some of the most vulnerable groups such as rural residents seeking specialized care in urban areas, the very poor, and pensioners on fixed incomes. Many providers and public informants expressed concern that informal payments cause hardships for these vulnerable populations.

Strategies could also inform patients about their legal rights and provide means to report providers to authorities in cases of abuse. Providers and the public both perceive that the laws against informal payments are not enforced, and that the public has no recourse. Another proposed action to

build trust is to convince the Order of Physicians of Albania to take a stand against informal payments. Physicians are traditionally respected leaders in Albania. It was a cardiologist who went on national television in 1997 and convinced citizens to stop the rioting and looting that was going on following the collapse of the pyramid financial schemes. This study confirmed that this traditional leadership role of physicians is not forgotten, but that it is vulnerable. It will be important to assure the Order of the Physicians that it is possible to restore public trust and the reputation of physicians as societal leaders by backing efforts to reduce informal payments. Revisions to the current Code of Medical Ethics and Deontology to include specific articles regulating the practice of informal payments could be considered.

4. Both insured and uninsured patients are making informal payments. The practice of informal payments may be reducing public willingness to participate in the social insurance system.

The study findings showed that both insured and uninsured patients were making informal payments. At the same time, some providers claimed not to charge official fees to uninsured patients for fear the official fees would be mistaken for informal payments. Many people didn't know where to find official price lists or to whom those prices apply. These findings imply that the unwillingness of some people to enroll in the national health insurance program may be related to the practice of informal payments.

Information, education, and communication strategies could educate the general public about their entitlements to health services, with and without insurance coverage. Education programs could improve the public's understanding of how social insurance and official user fees work. Patient and citizen education will be challenging to implement, and innovative strategies should be tested and evaluated to assure that the most effective programs are put in place.

5. Health reforms cannot easily separate or ignore gift giving, although the effects of gift giving on provider behavior and accountability are not well understood.

Generally, informants in this study expressed positive attitudes about gifts, compared with their negative attitudes toward other types of informal payments. Although gifts may be more acceptable to informants than other types of informal payments, the results still suggest concerns about the effects of gift giving on accountability. First, the research shows that there are not clear boundaries between informal payments and gifts. "Have a coffee" may be a gift, but it also can be an informal payment, depending on the situation, context, and perceptions of the giver and receiver. In addition, gifts may be used to entice or motivate providers' future care-giving behavior, and the anticipation of receiving gifts, could influence provider decisions. Finally, gift giving may be an excuse for providers to accept all kinds of informal payments.

Planners may want to examine the possible benefits of promoting ways for people to thank government health workers through the institution, rather than individually. Part of the tradition of gift giving in Albania comes from a social or moral obligation to show appreciation for a service offered or an outcome received. In the United States, one response to this desire to show appreciation has been to create ways people can thank public employees or health workers through the institution, not individually (Rose-Ackerman 1999). Collective gifting fulfills the social or moral obligation while reducing the problematic material incentive the gift might represent. It also reduces the potential advantage that the gift giving tradition gives to wealthier people who are able to provide more lavish gifts, thus possibly gaining advantages in terms of access or service. It is worth exploring whether there might be ways to increase the appeal of collective giving options that are less vulnerable to possible abuse or corruption.

6. People generally look to the state to end informal payments, but they also see value in community participation to enhance accountability. Getting ordinary citizens involved in oversight and transparency initiatives may be a useful complement to regulatory and bureaucratic reforms.

Most public informants in this study thought that the state should take responsibility for ending informal payments. The reliance on government to provide solutions is not surprising, given Albania's short history as a democracy. The study also asked respondents to consider the potential of community health boards in monitoring informal payments and reducing abusive practices. Some respondents were receptive to this idea and saw potential benefits in having additional transparency. Other informants were concerned that community members have no experience with boards and will need extra support and training to develop their ability to act as watchdog. A few people expressed worry that board members might not be selected in a transparent way.

Health boards can be an important structure for promoting transparency and accountability. In Bolivia, health board involvement has been associated with lower rates of informal payments (Gray-Molina, Perez de Rada, et al. 2001). Management Sciences for Health has developed many materials on the roles of health boards, especially regarding the role of community boards in overseeing public sector user fee systems with facility- or district-level fee retention (Collins, Quick, et al. 1996; Newbrander, Collins, et al. 2000).

Health planners in Albania might want to explore options for introducing community health boards in facilities and districts. A study tour to another country in the region may be helpful to develop confidence, provide applicable models, and suggest practical implementation strategies. It will be important to link health board responsibilities to administrative reporting and health information systems, as transparency goals are promoted by building the skills of community board members in reading and analyzing financial information and health utilization data.

7. Conclusion

In the eyes of Albanian providers and the public, informal payments are both a necessary coping mechanism and a destructive practice that hurts efficiency, trust, and health. Informal payments are motivated by many factors, and great variation exists in perceptions of gifts versus other informal payments, the process of making informal payments, and people's attitudes toward the payments. Public discussion is needed to air these differences and to explore common interests. A coalition of stakeholders working with a mutually agreed upon agenda for change can help lead the way on the road back to accountable public services that promote the nation's health. Accountability will be enhanced as government officials and civil society work together to identify possible solutions and decide what roles government and the people should play in implementing change.

Annex A: Recent Literature on Informal Payments in Transition Economy Countries

Research in other transitional economy countries has provided evidence of the types, scope, and exchange of informal payments. Some observations are summarized here:

- Informal payments for health services tend to be more frequent in urban areas (Thompson and Witter 2000; Belli, Shahriari, et al. 2002), possibly because community ties in rural areas act as a deterrent.

- Informal payments occur more often in inpatient care settings and are linked to surgery or childbirth procedures (Balabanova and McKee 2002; Falkingham 2004). They also tend to be higher for providers with more qualifications and better reputation (Balabanova and McKee 2002).

- Informal payments can be cash or in-kind (Lewis 2000; Thompson and Witter 2000). Some studies have categorized the medicines and other supplies purchased by patients as "in-kind informal payments" (Falkingham 2004).

- In most studies on informal payments, gifts are considered a type of informal payment (Thompson and Witter 2000; Balabanova and McKee 2002; Ensor 2004; Falkingham 2004). Providers are more likely to report accepting a payment after service is provided, so that it appears to be a gift rather than a bribe or an illicit fee for service (Balabanova and McKee 2002). Gifts given after treatment may be considered less troublesome than cash informal payments given before treatment, because the motivation of a gift is generally to express gratitude and not a required "quid pro quo" (Balabanova and McKee 2002). Yet, studies have noted that gifts can be given to influence future treatment, and it is sometimes difficult to distinguish gifts from other types of informal payments (Balabanova and McKee 2002).

- Factors that seem to drive the practice of informal payments include:

  - Inadequate compensation of health care providers;
  - Insufficient budgets for financing of government-mandated "free" health services;
  - Perceived low levels of quality;
  - A desire to get additional services or better quality beyond the basic package guaranteed by government;
  - Gift-giving traditions;
  - Changes in social norms following significant political, economic, or social events

(Lewis 2000; Thompson and Witter 2000; Miller, Grodeland et al. 2001; Belli, Shahriari, et al. 2002; Akashi, Yamada, et al. 2004; Ensor 2004; Falkingham 2004).

- The practice of informal payments is difficult to measure. This is due in part to people's

reluctance to admit that they engage in illegal or socially undesirable activities. Also, people are sometimes confused about official versus unofficial payment policies or insurance program benefits and requirements such as co-payments (Balabanova and McKee 2002; Falkingham 2004).

- General public respondents and patients often report being asked to make an informal payment, either directly or indirectly through innuendo (Balabanova and McKee 2002; Belli, Shahriari, et al. 2002).

- Providers sometimes will negotiate the price of informal payments, asking for less from lower-income patients (Belli, Shahriari, et al. 2002; Falkingham 2004).

Annex B: Selection of Respondents

General Public Respondents

Qualitative researchers generally try to use methods that reduce selection bias and increase the likelihood that informants are representative of the population being studied (Krueger and Casey 2000). To select respondents who would represent the views of the Albanian public in the three districts included in this study, the research team randomly selected the villages or urban neighborhoods where the focus groups were held. The team first compiled a list of all the villages or neighborhoods in each district. The lists were sorted into rural and urban villages/neighborhoods. For each district, the team used the random number generator function (RAND) in Microsoft Excel software to randomly choose two rural villages and two urban villages/neighborhoods.

Within each village, the team of Albanian research assistants used one of several methods to recruit focus group participants.

In Berat, for three of the focus group discussions, researchers went door-to-door (knocking on every third door) to invite adults to attend focus groups. Only one adult per household was selected (the household head, where available). For the fourth focus group, researchers invited a group of men they met by chance in the street.

In Kuçova, two groups were assembled by going door-to-door to seek participants, while two groups were assembled from people met by chance on the street. In Fier, two groups included people met by chance in the street, one group included women visiting a hair salon, and one group included patrons of a coffee shop. Researchers held the focus groups in a variety of locations, including coffee shops, parks, schools, libraries, and hair salons. Table B-1 gives the breakdown of the total number of general public respondents (80) by district, urban or rural location, gender, and type of interview (focus group discussion or in-depth interview).

Table B-1: Number of General Public Respondents, By District, Urban vs. Rural, Gender, and Type of Interview

District	Urban/ Rural	Male		Female	
		FGD	IDI	FGD	IDI
Berat					
	Urban	6	3	6	0
	Rural	6	0	6	0
	Total	12	3	12	0
Kuçova					
	Urban	6	1	6	1
	Rural	6	1	6	0
	Total	12	2	12	1

District	Urban/ Rural	Male		Female	
		FGD	IDI	FGD	IDI
Fier					
	Urban	5	0	8	2
	Rural	4	1	6	0
	Total	9	1	14	2
Total All Districts					
	Urban	17	4	20	3
	Rural	16	2	18	0
	Total	33	6	38	3

FGD = Focus Group Discussion, IDI = In=Depth Interview.

Provider Respondents

To select provider respondents, the research team first made a list of each of the health facilities in each district. The team sorted the lists by location (urban versus rural), and used the Excel random number generator to select six urban and six rural facilities in each district. The facilities included public ambulanzas, primary health centers, maternity centers, polyclinics, and hospitals (no private facilities). From the selected facilities, the team obtained a list of all doctors and all nurses. The team then used the random number generator to select one nurse and one doctor from each facility. The researchers also randomly selected alternative doctors and nurses, in case some of the original people who were invited decided not to participate. We chose to invite only one doctor and one nurse per facility as a precaution to assure confidentiality and to encourage open and honest communication in focus group discussions. Overall, five providers refused to participate (two doctors and three nurses, all but one in urban areas), and four providers could not be found or were on leave (one doctor and three nurses, all but one in urban areas).

During the pilot test, the researchers found that some providers were reluctant to answer questions when interviewed alone, but that when interviewed in a focus group they were more communicative. The team thought that perhaps people felt more anonymous and protected in the group, and therefore more inclined to share their opinions. At the same time, facilitators sometimes found it hard to draw out everyone's opinions when focus groups were large. In order to give everyone sufficient chance to voice their opinions, the researchers decided to schedule smaller focus groups, with four participants in each. Nurse focus groups were held separately from doctor focus groups. The team chose not to schedule focus groups in Kuçova because it is so small that most providers already know each other and might be reluctant to share their opinions. In the end, the study only held provider focus groups in Fier, because providers in Berat were also reluctant to participate in focus groups. The research team chose two government health administrators to interview in each district based on their availability and interest in participating in the study. Table B-2 shows the total number of provider respondents (51) by district, type of provider, urban or rural location, and type of interview (focus group discussion versus in-depth interview).

Table B-2: Number of Provider Respondents, By District, Type of Provider, Urban vs. Rural, and Type of Interview

District	Type	Urban		Rural	
		FGD	IDI	FGD	IDI
Berat					
	Doctor	0	5	0	3
	Nurse	0	3	0	4
	Admin	0	2	0	0
	Total	0	10	0	7
Kuçova					
	Doctor	0	4	0	3
	Nurse	0	3	0	3
	Admin	0	2	0	0
	Total	0	9	0	6
Fier					
	Doctor	4	1	0	3
	Nurse	4	1	3	1
	Admin	0	2	0	0
	Total	8	4	3	4
Total All Districts					
	Doctor	4	10	0	9
	Nurse	4	7	3	8
	Admin	0	6	0	0
	Total	8	23	3	17

FGD = Focus Group Discussion, IDI = In-Depth Interview

Annex C: Topic Guides for Focus Groups and Interviews

PHR*plus* Informal Payments Study

FOCUS GROUP DISCUSSION GUIDE FOR GENERAL PUBLIC

Moderator Checklist:

- ❑ **Date** _____
- ❑ **Moderator** _____
- ❑ **Note Taker/Recorder** _____
- ❑ **District** _____
- ❑ **Urban or Rural** _____
- ❑ **Village/Town** _____
- ❑ **Start Time** _____
- ❑ **Finish Time** _____
- ❑ **No. of Participants** _____
- ❑ **Focus Group ID#** _____

  (First initial of district – FGD – GP – Sequential number)

- ❑ ***NOTE: Please make sure all participants have read and signed the Informed Consent Form before beginning the focus group discussion.***

Introduction

Hello and welcome to this discussion. My name is _____ I am a researcher with the USAID-funded project which is called the Partners for Health Reform*plus* (PHR*plus*) Project. The PHR*plus* project has been working closely with the Government of Albania to investigate ways to improve the provision of primary health care services, including health financing reforms.

We are conducting a study that aims to improve health care financing and delivery in Albania. **As part of this study, we would like to discuss your experiences with and opinions about things or money given to public health facility staff for services in cases where payment is not required by the government. We are talking about supplementary or "informal" payment. We are not talking about official fees.**

I will be facilitating the discussion and my colleague _____ will be taking notes. The discussion will also be audio taped. No one will have access to these tapes except the research team, and none of you will be identified by name, to ensure your privacy. We would also like to request that the information we talk about during this discussion not be shared with or repeated to anyone outside of this group when we are finished.

We would like you to read this form, which explains the study and your voluntary participation in it. If you agree to participate in the study, we would like you to sign this form before we begin the discussion.

NOTE TO MODERATOR:

1. MAKE SURE EACH PERSON WHO WANTS TO PARTICIPATE HAS READ AND SIGNED AN INFORMED CONSENT FORM.
2. MAKE SURE THE TAPE RECORDER IS WORKING.

Let's begin the discussion. There is no one right answer, so please feel free to agree or disagree with what other participants say.

1. **We just introduced the topic of unofficial or informal payments. What are the words people use to describe this type of payment?**

   Probe: What would a patient say to a provider, and what might a provider say to the patient to talk about this? What might you say to a friend to describe this?

2. **What do people give to providers other than official fees?**

   Probe: Why?

   Probe: People say these payments occur due to culture and tradition. What do you think about this? (How have the payments changed over time, and why? How have services changed over time? How has this influenced the payments?)

3. **For what kinds of services or providers do people give these payments?**

4. **Are there different types of payments given to different services?**

   Probe: Can you give some examples of times when people would not give payments?

   Probe: What would happen if people did not make the payments?

5. **What is the difference between people who do and do not give payments?**

6. **What is the result in services where payments are given and not given?**

   Follow-up: Can you give any examples?

7. **What are the ways people make these payments?**

8. **How do people learn how much the informal payment should be?**

9. **What kinds of things do people use to pay, and when do they pay?**

10. **Who do they give informal payment to?**

11. **Can you describe whether the order of events (that is, when a payment is made, whether the informal payment is made before or after services are provided) can have an affect on the quality or on the speed of service?**

    Follow-up: Can you give any examples?

12. **What do you think about informal payments?**

    Follow-up: What is good and what is bad about the payments?

    Probe: Who is helped, or what benefits come from these payments? Who is hurt, or what harm comes from these payments?

    Probe: How have services changed over time and how have payments changed over time?

13. **What do you think is already being done about informal payments, and what do you think about it?**

    Probe: who is doing something, is it NGOs, government, private clinics, citizen groups, or others?

14. What do you think should be done about informal payments in the future?

    Follow-up: What should providers, administrators, community members, and patients do?

    Probe: What would be necessary to make this happen? What are the obstacles that would need to be overcome?

15. **Do you have any other thoughts to add about informal payments?**

Those are all the questions that I had for you. Do you have any questions for me?

Thank you very much for your participation.

PHR*plus* Informal Payments Study

IN-DEPTH INTERVIEW GUIDE FOR GENERAL PUBLIC

Moderator Checklist:

- ❑ **Date** _____
- ❑ **Moderator** _____
- ❑ **Note Taker/Recorder** _____
- ❑ **District** _____
- ❑ **Urban or Rural** _____
- ❑ **Village/Town** _____
- ❑ **Male or Female** _____
- ❑ **Start Time** _____
- ❑ **Finish Time** _____
- ❑ **Interview ID#** _____

  (District First Letter – IDI – GP – Sequential Number)

- ❑ ***NOTE: Please make sure the participant has read and signed the Informed Consent Form before beginning the interview.***

Introduction

Hello and welcome to this discussion. My name is _____ I am a researcher with the USAID-funded project which is called the Partners for Health Reform*plus* (PHR*plus*) Project. The PHR*plus* project has been working closely with the Government of Albania to investigate ways to improve the provision of primary health care services, including health financing reforms.

We are conducting a study that aims to improve health care financing and delivery in Albania. This study will include approximately 150 people from the districts of Berat, Kuçova, and Fier. **As part of this study, we would like to discuss your experiences with and opinions about things or money given to public health facility staff for services in cases where payment is not required by the government. We are talking about supplementary or "informal" payment. We are not talking about official fees.**

I will be facilitating the discussion and my colleague _____ will be taking notes. The discussion will also be audio taped. No one will have access to these tapes except the research team, and none of you will be identified by name, to ensure your privacy.

We would like you to read this form, which explains the study and your voluntary participation in it. If you agree to participate in the study, we would like you to sign this form before we begin the discussion.

NOTE TO INTERVIEWER:

BEFORE YOU START:

1) MAKE SURE THE INFORMANT HAS READ AND SIGNED THE INFORMED CONSENT FORM.
2) MAKE SURE THAT THE TAPE RECORDER IS WORKING.

Let's begin. I will be using a general interview guide that will be used for all participants. Remember that you don't have to answer questions if you wish, and you can stop the interview at any time.

1. **Family and background**
    a. When were you born?
    b. Where do you live now?
    c. What level of education do you have?
    d. Are you married?
    e. Do you have children?

2. **Occupation**
    a. Do you work?
    b. What is your job?

3. Practice of Informal Payments

a. Have you ever made an informal payment for health care services? If no, do you know of any family member or close friend who has made an informal payment?

(If the informant has not made an informal payment and doesn't know a family member or friend who has made an informal payment, then interviewer should stop the interview to talk with Supervisor. With supervisor, the interviewer should adapt questions, then interview the respondent about attitudes toward informal payments in general.)

b. Where and when did you last make an informal payment for health services? Was the payment for you, or for a family member? What type of facility/health activity were you (or the family member) attending?

c. How was the payment made?

i. Who did you give it to (please describe all people who are paid, not only providers)?

ii. When and how did you know how much to give, and how did you know who expects to be paid?

iii. Do you ask a receptionist, nurse, doctor or other staff member? If not, why not?

iv. Did you pay cash or you gave anything else?

v. How much?

vi. How did you obtain the payment you needed—did you have the money, or did you have to borrow, sell assets, or otherwise raise the money?

d. Would the health personnel ever bargain with you on price? Why/why not?

e. Do you have to make the payment immediately, or would a provider accept to be paid later, after you have left the facility? If after, how does this work?

f. What services did you receive for the payment you made?

g. What do you think the informal payment you made was used for?

h. What other experiences have you had making informal payments (not only this last time)?

i. What do you know about how informal payments vary for different services or providers? For what reasons do the payments vary?

j. If you know how much different providers or services expect to be paid (informally), does the price affect which ones you decide to use? Why or Why not?

k. Do you seek other people's advice or their help in paying? How does this influence your choice of service?

4. Why do you make the payments? How did you feel about the experience of making the informal payment?

a. Was there anything positive about the experience? If so, what? (Probe: were there benefits for you?)

b. What concerns did you have about the experience?

5. **What are the terms people use to describe informal payments?**
    a. Did you consider the payment you made to be a gift? Why/why not?
    b. What is the difference between a gift and an informal payment, in your view?
    c. How would a patient talk about informal payments with a provider? What might the patient say, actually, and what might the provider say back?
    d. Some people say these payments occur due to culture and tradition. What do you think about this? (**Probe:** How have the payments changed over time, and why? How have services changed over time? How has this influenced the payments?)

6. **What do you think is already being done about informal payments, and what is your opinion about it?**

7. **The government is planning some health reforms that will improve the health care system and make it better financed and more accessible. These reforms might include increasing insurance coverage, increasing the wages of health workers, and increasing official fees.**
    a. How do you think these reforms will affect informal payments? Why/why not?
    b. What is your opinion about whether community members should play a role in making sure the new system works well?
        i. What role community members play, and how will it help?
        ii. Do you think it would help if each facility or level of the health care system has a community board? What might be good about this? What problems might there be?
    c. What effect do you think these reforms will have on informal payments?

Those are all the questions that I had for you. Do you have any questions for me?

Thank you very much for your time and information. It is greatly appreciated.

PHR*plus* Informal Payments Study

FOCUS GROUP DISCUSSION GUIDE FOR PROVIDERS

Moderator Checklist:

- ❑ **Date** _____
- ❑ **Moderator** _____
- ❑ **Note Taker/Recorder** _____
- ❑ **District** _____
- ❑ **Urban or Rural** _____
- ❑ **Village/Town** _____
- ❑ **Start Time** _____
- ❑ **Finish Time** _____
- ❑ **No. of Participants** _____
- ❑ **Focus Group ID#** _____

  (First letter of district – FGD – D (for doctors) or N (for nurses) – Sequential number)

- ❑ ***NOTE: Please make sure all participants have read and signed the Informed Consent Form.***

Introduction

Hello and welcome to this discussion. My name is _____ I am a researcher with the USAID-funded project which is called the Partners for Health Reform*plus* (PHR*plus*) Project. The PHR*plus* project has been working closely with the Government of Albania to investigate ways to improve the provision of primary health care services, including health financing reforms.

We are conducting a study that aims to improve health care financing and delivery in Albania. **As part of this study, we would like to discuss your experiences with and opinions about things or money given to public health facility staff for services in cases where payment is not required by the government. We are talking about supplementary or "informal" payment. We are not talking about official fees.**

I will be facilitating the discussion and my colleague _____ will be taking notes. The discussion will also be audio taped. No one will have access to these tapes except the research team, and none of you will be identified by name, to ensure your privacy. We would also like to request that the information we talk about during this discussion not be shared with or repeated to anyone outside of this group when we are finished.

We would like you to read this form, which explains the study and your voluntary participation in it. If you agree to participate in the study, we would like you to sign this form before we begin the discussion.

NOTE TO MODERATOR:
1. MAKE SURE EACH PERSON WHO WANTS TO PARTICIPATE HAS READ AND SIGNED AN INFORMED CONSENT FORM.
2. MAKE SURE TAPE RECORDER IS WORKING.

Let's begin the discussion. There is no one right answer, so please feel free to agree or disagree with what other participants say.

1. **We just introduced the topic of unofficial or informal payments. What are the words people use to describe this type of payment?**

   Probe: What would a patient say to a provider, and what might a provider say to the patient to talk about this? What might you say to a friend to describe this?

   Probe: How have payments changed over time, and why? How have services changed over time? How has this influenced the payments?

   Probe: What is the difference between a gift and an informal payment?

2. **What is your opinion about the effect of informal payments on the nature of services provided?**

3. **Why do you think informal payments take place in the health sector?**

   Probe: What are the reasons people make payments?

4. **What are the reasons providers accept them?**

5. **How do people make the informal payment?**

   Probe: When do people make the informal payment?

6. **Can you describe whether the order of events (that is, when a payment is made, whether the informal payment is made before or after services are provided) can have an effect on the quality or on the speed of service?**

   Follow-up: Can you give any examples?

7. **How do informal payments affect the way patients and providers relate to each other?**

   Follow-up: Can you give any examples?

8. **Please describe any positive sides or good things about informal payments.**

   Follow-up: Can you give any examples?

   Probe: Who benefits from informal payments, and how?

9. **Please describe any negative sides or bad things about informal payments.**

   Follow-up: Can you give any examples?

   Probe: Who is hurt, or what negative effects come from informal payments?

10. **Sometimes people's opinions or actions are influenced by what other people – friends, family, peers, professional societies – want them to do. What opinions are the most influential for doctors (or nurses) regarding professional conduct?**

    Probe: with regard to payments

    Follow-up: Can you give any examples?

11. **What do you think is already being done about informal payments, and what is your opinion about it?**

    Probe: who is doing something, is it NGOs, government, private clinics, citizen groups, or others?)

12. **The government is planning some health reforms that will improve the health care system and make it better financed and more accessible. These reforms might include increasing insurance coverage, increasing the wages of health workers, and increasing official fees.**

    How do you think the health reform process will affect informal payments?

13. **What do you think should be done about informal payments?**

    Probe: Who should do the things you suggest?

14. **Do you have any other thoughts about informal payments?**

Those are all the questions that I had for you. Do you have any questions for me?

Thank you very much for your participation.

PHR*plus* Informal Payments Study

IN-DEPTH INTERVIEW GUIDE FOR PROVIDERS

Moderator Checklist:

- ❑ **Date** _____
- ❑ **Moderator** _____
- ❑ **Note Taker/Recorder** _____
- ❑ **District** _____
- ❑ **Urban or Rural** _____
- ❑ **Village/Town** _____
- ❑ **Male or Female** _____
- ❑ **Start Time** _____
- ❑ **Finish Time** _____
- ❑ **Interview ID#** _____

  (District First Letter – IDI – D (for doctor) or N (for nurse) – Sequential number)

- ❑ ***NOTE: Please make sure the participant has read and signed the Informed Consent Form before beginning the interview.***

Introduction

Hello and welcome to this discussion. My name is _____ I am a researcher with the USAID-funded project which is called the Partners for Health Reform*plus* (PHR*plus*) Project. The PHR*plus* project has been working closely with the Government of Albania to investigate ways to improve the provision of primary health care services, including health financing reforms.

We are conducting a study that aims to improve health care financing and delivery in Albania. This study will include approximately 150 people from the districts of Berat, Kuçova, and Fier. **As part of this study, we would like to discuss your experiences with and opinions about things or money given to public health facility staff for services in cases where payment is not required by the government. We are talking about supplementary or "informal" payment. We are not talking about official fees.**

I will be facilitating the discussion and my colleague _____ will be taking notes. The discussion will also be audio taped. No one will have access to these tapes except the research team, and none of you will be identified by name, to ensure your privacy.

We would like you to read this form, which explains the study and your voluntary participation in it. If you agree to participate in the study, we would like you to sign this form before we begin the discussion.

NOTE TO INTERVIEWER:

BEFORE YOU START:

1) MAKE SURE THE INFORMANT HAS READ AND SIGNED THE INFORMED CONSENT FORM.
2) MAKE SURE THAT THE TAPE RECORDER IS WORKING.

Let's begin. I will be using a general interview guide that will be used for all participants. Remember that you don't have to answer questions if you wish, and you can stop the interview at any time.

1. Background and Occupation

a. Where do you work?
b. What is your position?
c. How long have you held your position?
d. How long have you been working in the Albanian health sector?

2. What are the terms people use to describe the payments?

a. How do people talk with the health personnel about informal payments? What might they say?
b. How have payments changed over time, and why? How have services changed over time? How has this influenced the payments?

c. What is the difference between a gift and an informal payment, in your view?

3. Practice of Informal Payments

a. Why do you think informal payments take place?

b. What are the reasons people make payments?

c. What are the reasons providers accept them?

d. Please describe any good things about informal payments. (Probe: who benefits from informal payments, and how?)

e. Please describe any bad things about informal payments. (Probe: who is hurt, or what negative effects come from informal payments, and what are they?)

4. **What is your opinion about the effect of informal payments on the type or nature of services provided?**

Probe: Does the order of events (when payment is made) have an effect on the quality or speed of service? Can you provide any examples?

5. How do informal payments affect the way patients and providers relate to each other?

6. Let's talk about the amount that people pay.

a. How is the amount that patients pay determined? How do patients know how much to pay?

b. What does the amount of the informal payment depend upon?

c. Are the informal payments different for different types of providers, or different kinds of services? Do most procedures or types of services have a standard "price"? Can you provide examples?

d. On what basis do prices vary? What about bargaining on price? Why does this/doesn't this happen?

7. When do patients make the informal payment?

a. Is it before or after the service is provided?

b. Do patients have to make the payment immediately, or would a provider accept to be paid later, after the patient has left the facility? If so, how does this work?

8. How do you feel about accepting informal payments?

a. Is it different from accepting gifts?

b. Was there anything positive about the experience? If so, what?

c. What concerns did you have about the experience?

9. **What do you think is already being done about informal payments, and what is your opinion about it?**

   Probe: who is doing something, is it NGOs, government, private clinics, citizen groups, or others?

10. **The government is planning some health reforms that will improve the health care system and make it better financed and more accessible. These reforms might include increasing insurance coverage, increasing the wages of health workers, and increasing the number of services for which patients will be asked to pay official fees.**
    a. How do you think these reforms will affect informal payments? Why/why not?
    b. What role community members play, and how will it help?
    c. Do you think it would help if each facility or level of the health care system has a community board? What might be good about this? What problems might there be?

Those are all the questions that I had for you. Do you have any questions for me?

Thank you very much for your time and information. It is greatly appreciated.

Informed Consent Form

Title of Study:

Qualitative study of the practice of informal payments in Albania

Sponsor:
PHR*plus* Project, Financed by USAID
Sky Tower Building Rr. Dëshmortët e 4 Shkurtit No. 5
Tirana, Albania

Research Purpose:
This is a study that involves research. The topic of this research is informal payments for health care services in Albania. Many people in Albania make payments for health care services that are supposed to be provided free-of-charge to the patient. The purpose of this research is to better understand people's perceptions, beliefs, and attitudes about these payments.

Number of People Participating:

This study will involve focus group discussions and interviews with about 160 Albanians, including members of the general public, health care providers (doctors and nurses), administrators and other key informants.

Time Required and Description of Procedures:

The interview or focus group will take about 1 to 1 ½ hours. The researcher will ask some general questions about informal payments in Albania. He or she may also ask some more specific questions about your own experiences. Throughout the interview, please feel free to add points or observations that seem important.

The interview will be audio taped to accurately capture your responses. These tapes may be transcribed. The tapes will be kept for one year and then will be erased.

Benefits and Risks:

There are no benefits to you from this research beyond feeling good about having had a chance to express opinions on this topic. The research will benefit scientific knowledge by increasing our understanding about how to design more appropriate health policies and programs for Albania.

The risk of the study is that you may experience inconvenience by having to take time from your work or other daily activities to participate in the interview or focus group.

For focus group discussions: The study team will keep all information gathered through this study confidential, and will request that all members of focus group discussions respect the privacy of other participants and not share information discussed during the discussions with anyone outside of the group. There is a risk, however, that other participants in the focus group may share information after leaving the group.

Confidentiality:

When writing up the research results your name will not be used. No one outside the research team will know who was interviewed or participated in this research.

Right to withdraw from participating:

Your participation in this research is completely voluntary and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

If after hearing this description of the research or at any time before the interview/focus group is completed you decide you do not want to participate in the research, you are free to leave and any information collected will not be used. Also, if you complete the interview/focus group but decide later that you don't want the information to be used, your information will be removed from the analysis up until the results are approved for publication or presentation.

Contact persons if you have further questions:

If at any time you have questions about this research, you may contact PHR*plus* Project at 04-221-666, extension 119, Sky Tower Building Rr. Dëshmortët e 4 Shkurtit No. 5 Tirana, Albania (This address and phone number are on your invitation letter. If you did not receive an invitation letter, please let us know.)

If you have concerns about this research that you do not feel comfortable addressing to the PHR*plus* Project in Albania, you can contact Kim Smith at the PHR*plus* Project in the United States, Kimberly_smith@abtassoc.com .

_____ _____

Name **Date of Informed Consent**

_____

Signature of Investigator

Annex D: Glossary of Albanian Words Used by Providers and Public Informants to Talk About Informal Payments

Albanian Word	Meaning or translation in English
Pagesat jo zyrtare	Informal payment
Shpërblimin nën dorë	Under-the-table payment
Ryshfet	Tip, bribe
Bakshish	Tip, bribe
Pazar	Bargain
Nën dorë	Secret payment
Dhurate	Gift, present
Peshqesh	Gift, present
Mikpritje	Gift, maybe something from the garden, or from a tree in one's yard, that is a sign of welcome
Shpieblim	Reward
Menaxher	Manager. A person who acts as a broker, negotiating payment between the patient or the patient's family and the doctors and other caregivers who are performing the procedure.

Annex E: References

Akashi, H., T. Yamada, et al. 2004. "User fees at a public hospital in Cambodia: effects on hospital performance and provider attitudes." *Social Science and Medicine* 58(3): 553-64.

Albania Ministry of Health. 2000. *Albanian Public's Perceptions of the Health Care System*. Tirana, Albania: Albanian Health System Recovery and Development Project.

Albania Ministry of Health. 2002. *10 Year Development Strategy of the Albanian Health System*. Tirana, Albania.

Balabanova, D. and M. McKee. 2002. "Understanding informal payments for health care: the example of Bulgaria." *Health Policy* 62(3): 243-73.

Belli, P., H. Shahriari, et al. 2002. *Qualitative Study on Informal Payments for Health Services in Georgia*. HNP Discussion Paper. The World Bank, Health, Nutrition, and Population: 63.

Bonilla-Chacin, M. E. 2003. *Health and poverty in Albania: Background paper for the Albania Poverty Assessment, Europe and Central Asia Sector for Human Development*. Washington, DC, World Bank: 1-59.

Brinkerhoff, D. 2003. *Accountability and health systems: overview, framework, and strategies*. Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates, Inc.

Chawla, M., P. Berman, et al. 1998. "Financing health services in Poland: new evidence on private expenditures." *Health Economics* 7(4): 337-46.

Collins, D., J. D. Quick, et al. 1996. *Health financing reform in Kenya: the fall and rise of cost sharing, 1989-1994*. Boston, MA: Management Sciences for Health.

DiTella, R. and W. Savedoff. 2001. *Diagnosis Corruption: Fraud in Latin America's Public Hospitals*. Washington, DC: Inter-American Development Bank.

Ensor, T. 2004. "Informal payments for health care in transition economies." *Social Science and Medicine* 58(2): 237-46.

European Observatory on Health Care Systems. 1999. *Health Care Suystems in Transition: Albania*. Copenhagen.

Falkingham, J. 2004. "Poverty, out-of-pocket payments and access to health care: evidence from Tajikistan." *Social Science and Medicine* 58(2): 247-58.

Gray-Molina, G., E. Perez de Rada, et al. 2001. "Does voice matter? Participation and controlling corruption in Bolivian hospitals." In Di Tella, R. and W. Savedoff. 2001. *Diagnosis corruption: fraud in Latin America's public hospitals*. Washington, DC: Inter-American Development Bank: 27-56.

International Monetary Fund. April 2004. *World Economic Outlook*.

Krueger, R. A. and M. A. Casey. 2000. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, CA: Sage Publications, Inc.

Lewis, M. 2000. *Who is paying for health care in Eastern Europe and Central Asia?* Paper prepared for the Human Development Sector Unit, Europe and Central Asia Region. Washington, DC: World Bank: 1-30.

Miller, W. L., A. B. Grodeland, et al. 2001. *A culture of corruption? Coping with government in post-communist Europe*. Budapest and New York: Central European University Press.

Newbrander, W., D. Collins, et al. 2000. *Ensuring equal access to health services: user fee systems and the poor*. Boston, MA: Management Sciences for Health.

Nuri, B. 2002. *Health Care Systems in Transition: Albania*. E. Tragakes. Copenhagen: European Observatory on Health Care Systems.

Partners for Health Reform*plus* Project. 2003. *Albania Proceedings Report, National Dissemination Workshop, Results of the Household Survey*. Mak Albania, Durres.

Rose-Ackerman, S. 1999. *Bribes, patronage, and gift giving. Corruption and government: causes, consequences, and reform*. Cambridge: Cambridge University Press.

Stover, C. C. 2001. *Health Financing and Reform in Kenya: Lessons from the Field. A Summary and Assessment of the Major Accomplishments of the APHIA Financing and Sustainability (AFS) Project, December 1996-June 2001*. Boston, MA, Management Sciences for Health.

Thompson, R. and S. Witter 2000. "Informal payments in transitional economies: implications for health sector reform." *Int J Health Plann Manage* 15(3): 169-87.

Valdelin, J. 2002. *Partners for Health Reformplus Project, Country Assistance Plan, Albania*. Tirana, Albania: PHR*plus*, Abt Associates, Inc.

Vian, T. 2003. *Corruption in the health sector in Albania.* Consultant report prepared for the USAID Corruption Reduction Project in Albania, Management Systems International. Boston, MA: Boston University School of Public Health.